EXHIBIT 2A

AMENDED AND RESTATED ADOPTION AGREEMENT FOR THE HEALTH & WELFARE PLAN OF THE CHIMES, D.C., INC.

Effective as of March 15, 2004, THE CHIMES, D.C., INC., a District of Columbia corporation ("Employer") adopts this Adoption Agreement and the Health & Welfare Plan of THE CHIMES, D.C., INC., (collectively "Plan"), which together constitute an amendment and restatement of the Amended and Restated Adoption Agreement for The Chimes, D.C., Inc. Health & Welfare Plan ("Prior Plan"). This Plan supersedes and replaces the Prior Plan.

RECITALS

The purposes of this Plan are to (1) bring the Plan into compliance with recent multiple changes in applicable law, (2) assure compliance with existing law and (3) provide health and welfare benefits for certain eligible employees of Employer and their eligible dependents.

This Plan is intended to comply with the applicable requirements of the Internal Revenue Code of 1986, as amended ("Code") and the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

1. ADOPTION OF PLAN

A. By adopting the Plan, Employer agrees to be bound by the terms of this Adoption Agreement and Exhibits thereto, and the Plan and Exhibits thereto, in the form attached to and made a part of this Adoption Agreement. Employer acknowledges its obligation to make contributions of amounts required by this Adoption Agreement, the Plan and the related Trust Agreement ("Trust").

B. This Plan Number for reporting and disclosure purposes for this Plan will be: 501.

2. EMPLOYER INFORMATION

A. Entity Type. The Employer is a corporation, incorporated under the laws of the District of Columbia.

B. Employer Tax Identification Number: 54-1691953.

3. EMPLOYER CONTRIBUTIONS

Employer will contribute on behalf of each eligible Employee an amount determined by an Employer/Employee agreement, an Employer/Client agreement, an Employer/Contracting Agency agreement, or a DOL Wage Determination Schedule or similar arrangement.

Those eligible Employees and Dependents and the related contribution amounts will be based on each New Group Information Sheet attached to and made a part of this Plan as Exhibits A-1, A-2 and following for each separate group that participates in the Plan. The New Group Information Sheet will contain, among other items, the contract site location and the contribution obligation for that site, as modified from time to time under the Plan.

4. DEFINITIONS

All capitalized terms under this Adoption Agreement will have the meanings defined in the Plan or Trust Agreement unless modified in this Adoption Agreement, or the context of this Adoption Agreement indicates a different meaning.

5. ALTERATION OF ADOPTION AGREEMENT

No change or amendment to this Adoption Agreement will be effective unless both Employer and the Plan's Third Party Administrator have approved that change in writing.

6. MISCELLANEOUS

This Agreement may be executed in one or more counterparts, each of which will be deemed an original, but all of which together will constitute a single document. This Adoption Agreement and Exhibits thereto, and the Plan and Exhibits thereto, will each become effective on the execution of a counterpart of it by each party to this Agreement.

IN WITNESS OF THIS ADOPTION AGREEMENT, Employer verifies, acknowledges and approves the information provided herein to include the Adoption Agreement and Exhibits thereto, which consists of the Third Party Administrator Agreement and the Fee Schedule, and the Plan and Exhibits thereto, which consists of the New Group Information forms, PHI Certification and Schedule 'I' and the Business Associates Agreement, and has executed this Adoption Agreement this ___ day of _____, 2004.

EMPLOYER/PLAN SPONSOR/PLAN ADMINISTRATOR

THE CHIMES, D.C., INC.

By: _____
Albert Bussone

Title: Vice President

THIRD PARTY ADMINISTRATOR

FCE BENEFIT ADMINISTRATORS, INC.
A California Corporation

By: _____
Gary Beckman, President, CEO

EXHIBIT 2B

THE HEALTH & WELFARE PLAN

THIS HEALTH and Welfare Plan is adopted by the Employer described in the Adoption Agreement of which this is a part.

Employer intends that the Plan and Trust qualify as a bona fide plan within the meaning of Section 2 of the Service Contract Act of 1965 (41 USC 351) and as an employee welfare benefit plan under Section 3(3) of ERISA (29 USC 1002). It is intended to comply with regulations established under laws such as the McNamara-O' Hara Service Contract Act (41USC 351, et seq.) Davis-Bacon Act (40 USC 276a-276a-7) Davis-Bacon and Related Acts, or prevailing or living wage laws or ordinances established by a state or political subdivision.

I. DEFINITIONS

The following terms will have the indicated meanings for the Adoption Agreement, Plan, Trust and related documents unless otherwise indicated in those documents. Definitions set out in the Summary Plan Description are hereby incorporated by reference.

1.1 "Contracting Agency" shall mean any Federal, State, municipal or other contracting authority which has the power to require the Employer to pay specific fringe dollar amounts for its Employees.

1.2 "Contribution" shall mean the Fringe Benefit Amounts, which Employer is required to pay for its Employees' benefits by the Contracting Agency, as amended from time to time. Contribution shall also mean the Fringe Benefit Amounts, which Employer is required to pay for its Employees' benefits by virtue of any Federal, State, municipal or other ordinance or statute, as amended from time to time. Contribution shall also mean amounts, which Employer is required to pay for its Employees' benefits, which are agreed upon between the Employer/Sponsor, Trustee and TPA for the Employees who are not governed or regulated by a Contracting Agency. Contribution shall also mean the total hourly, weekly or monthly actual or actuarially determined cost of Employee benefits, which may differ from the amount Employer is paying or is required to pay for its Employees.

1.3 "Earned Hours" shall mean the hours for an Employee which are required to be credited to that Employee by the Contracting Agency, ordinance, statute or agreement, to determine Fringe Benefit Amounts for the payroll periods in the month preceding the month in which Employer is required to make its Contribution.

1.4 "Earned Hours Record" shall mean Employee information necessary to support the Employer Contribution for Earned Hours and ascertain the appropriate level of Employee benefits under the Plan. This information shall include, but not be limited to, each Employee's name, social security number, date of hire, date of termination, Earned Hours, Fringe Benefit Amountse and total Contribution for that Employee for the payroll periods relating to those Earned Hours.

1.5 "Employee" shall mean each common law employee of Employer who is employed under a Service Contract issued by a Contracting Agency, or who is otherwise designated by Employer as a participant in the Plan. "Employee" shall also mean each common law employee of Employer who is employed under a Service Contract between Employer and another legal entity wherein certain Employer payroll related obligations are governed by any Federal, State, municipal or other ordinance or statute. "Employee" shall also mean each employee of an entity with whom Employer is providing services and for whom Employer has agreed to make Contributions to Employer's Health and Welfare Plan in accordance with the Trust. This includes, but is not limited to, joint venture partner, prime contractor and sub-contractor relationships.

1.6 "Employer" means the employer described in the Adoption Agreement, and any successor or assign of the employer and any other company which is related or affiliated or engaged in a joint venture with the employer.

1.7 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.8 "Fringe Benefit Amounts" shall mean the dollar amount per hour, or other period, which Employer must contribute for each Employee under each applicable Service Contract.

1.9 "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

1.10 "Insurer" shall mean the insurance company that provides benefits under the Plan through a policy of insurance.

1.11 "Participant" shall mean any Employee or Dependent who is covered under this Plan.

1.12 "Plan" shall mean the Adoption Agreement, which includes the Health & Welfare Plan, the Fee Schedule (Exhibit A to the Adoption Agreement), the Third Party Administrator Agreement (Exhibit B to the Adoption Agreement), the Summary Plan Description, the Group Information Form (Exhibit A to the Health and Welfare Plan), the Plan Sponsor Certification for Compliance With Privacy Standards (Exhibit B to the Health and Welfare Plan), the Business Associate Agreement for Compliance With Privacy Standards (Exhibit C to the Health and Welfare Plan) and Funding Policy for Health and Welfare Plan (Exhibit D to the Health and Welfare Plan) and all attachments and documents incorporated by reference.

1.13 "Plan Administrator" within the meaning of Section 3(16)(A) of ERISA shall mean the Employer.

1.14 "Service Contract" shall mean any contract under which Employer is required to provide employee services to a government agency or similar entity and for which Employer has adopted this Plan to satisfy Employer's fringe benefit obligations there under.

1.15"SPD" shall mean the Major Medical Benefits Summary Plan Description or the Primary Care Plan Summary Plan Description for each Group Information Form attached to and made a part of this Plan as an Exhibit A.

1.16 "Third Party Administrator" or "TPA" shall mean FCE Benefit Administrators, Inc., a California corporation, and any successor.

II. PARTICIPATION

2.1 Eligibility. An Employee will be eligible to become a Participant in the Plan two months to the date after that Employee begins continuous service on behalf of the Employer under a Service Contract unless otherwise stipulated in a collectively bargained agreement between the Employee and the Employer. 2.2 Cessation of Participation. All rights to receive benefits for claims of a Participant, and any spouse, Dependent (as defined in the SPD) or both of that Participant will terminate on the events and at the time described in the SPD.

III. BENEFITS

3.1 Benefits. Each Participant will be entitled to the benefits described in the Summary Plan Description, as amended from time to time under the Plan.

3.2 Exclusions. No reimbursement will be made for any expenses that are excluded under the Summary Plan Description.

IV. PLAN ADMINISTRATION

4.1 Employer Responsibilities. Employer will have the authority to appoint a Third Party Administrator to administer the Plan unless Employer chooses to administer the Plan. If a Third Party Administrator is appointed, that Third Party Administrator will carry out the responsibilities of Employer which are specifically delegated to the Third Party Administrator under this Plan and the related Third Party Administrator Agreement.

4.2 Powers and Duties of Employer. Subject to the limitations of the Plan, the Employer shall establish rules of the administration of the Plan and the transaction if its business. The Employer has the exclusive right (except as otherwise provided in the Plan) to interpret the Plan and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Employer in respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Employer has the following powers and duties:

a. To require any person to furnish such information, including, but not limited to, execution of any agreements, as the Employer may request for the purpose of the proper administration of the Plan as a condition to receiving any Benefits under the Plan;

b. To make and enforce suck rules and regulations and prescribe the use of such forms as the Employer deems necessary for the efficient administration of the Plan;

c. To decide on questions concerning the Plan and the eligibility of any employee to participate in the Plan, in accordance with the provisions of the Plan, and;

d. To determine the amount of Benefits which shall be payable to any person in accordance with the provisions of the Plan, to inform the Employer of the amount of such Benefits and to provide a full and fair review to any Participant whose claim for Benefits has been denied in whole or in part.

In carrying out its duties herein, the Employer shall have discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it, and its determination shall be given deference and shall be final and binding on all interested parties.

4.3 Records and Reports. Except to the extent delegated to the Third Party Administrator under the Third Party Administrator Agreement, Employer will be responsible for keeping a record of all its proceedings and actions and will maintain all those books of account, records, and other data necessary to administer this Plan and to meet the disclosure and reporting requirements of ERISA.

4.4 Participant's Incapacity. If a physician, psychiatrist or other person satisfactory to Employer or Third Party Administrator certifies in writing that a person entitled to receive a payment under this Plan is under a legal disability, is a minor or is incapacitated in any other way so as to be unable to personally receive and give a valid receipt for any payment due him or her under the Plan, then Employer or Third Party Administrator may, unless a claim has been made by a duly appointed guardian, conservator or trustee for that person, make the payment of benefits to that person's spouse, child, parent or any other person deemed by Employer or Third Party Administrator to have incurred an expense for or assumed responsibility for the expenses of that person. Any payment made under this Section will be a complete discharge of any liability for making that payment under the provisions of this Plan.

4.5 Bonding. An ERISA bond or any other bond, as required by law, will be secured by this Plan.

4.6 Insurer Responsibilities. To the extent that any Plan benefits are provided by an Insurer under an insurance policy covering Employees of the Employer, the Insurer will have the power in its sole and absolute discretion to interpret the provisions of its insurance policy including, but not limited to, eligibility for coverage, eligibility for benefits, benefits amounts, decisions on appeals, and all other matters relating to such insurance policy. The Plan allocates to the Insurers responsibility for administering the Plan's claims procedures and for exercising other fiduciary functions described in the insurance policy issued by such Insurers, which also contain the rules for determining eligibility to participate in each insured program and eligibility to receive benefits under each insured program.

V. CLAIMS PROCEDURES

5.1 Claims Procedures. All procedures for review of claims, claims denials and appeals of claims will be determined under the following procedures:

Initial Claims

Initial claims for Plan benefits are made to the Plan Administrator providing that benefit. The Plan Administrator will review the claim itself or appoint an individual or an entity to review the claim, following these procedures:

(a) Non-Health Benefit Claims. In the case of a claim that is not a health claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives

written notice from the reviewer before the end of the 90 day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond the day which is 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the Claimant's claim is for urgent care health benefits, the reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the reviewer will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could be adequately managed with the care or treatment which is the subject of the claim.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment of termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the reviewer will notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. In the case of a health benefit claim not described above:

a. In the case of a pre-service health benefit claim, the reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. If, due to special circumstances, the reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the reviewer expects to make its decision. Under no circumstances may the reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

b. In the case of a post-service health benefit claim, the reviewer will notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the reviewer expects to make its decision. Under no circumstances may the reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information

necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment of services which the Claimant has already received.

(c) Manner and Content of Denial of Initial Claims. If the reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

(i) A description of the specific reasons for the denial;

(ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;

(iii) A description of any additional information that the Claimant must provide in order to perfect the claim (including an explanation of why the information is needed);

(iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial; and

(v) A statement of the Claimant's right to bring a civil action under a Federal law called "ERISA" following any denial on review of the initial denial.

In addition, in the case of a denial of health benefits, the following will be provided to the Claimant:

(i) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that a copy will be provided without charge upon request); and

(ii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, and explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that an explanation will be provided without charge upon request).

(In the case of an adverse benefit determination concerning a health claim involving urgent care, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with the Section is furnished not later than 3 days after the oral notification.)

Reviews of Initially Denied Claims

If a claim is submitted for Plan benefits and it is initially denied under the procedures described above, the claimant may request a review of that denial under the following procedures.

(a) Non-Health Benefit Claims. In the case of benefits other than health benefits, a request for review of a denied claim must be made in writing to the Plan Administrator within 60 days after receiving notice of the initial denial of the claim. The decision on review will be made within 60 days after the Plan Administrator's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than one hundred twenty (120) days after receipt of a request for review.

The reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Plan Administrator. The reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health Benefit Claims. A Claimant whose initial claim for health benefits is denied may request a review of that denial by submitting the request in writing to the Plan Administrator no later than 180 days after the Claimant receives the notice of an adverse benefit determination. In addition to providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is

experimental, investigational or not medically necessary of appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(iv) In the case of a requested review of a denied initial claim involving urgent health care, the review process shall meet the expedited deadlines described below. The Claimant's request for such an expedited review may be submitted orally or in writing by the Claimant and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. In case of urgent care health claims, the reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of the initial adverse determination by the Plan.

(ii) Other Health Benefit Claims.

a. In the case of a pre-service health claim, the reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of the Claimant's request for review of the initial adverse determination.

b. In the case of a post-service health claim, the reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after receipt by the

Plan of the Claimant's request for review of the initial adverse determination.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial determination, the reviewer will provide the Claimant a written or electronic notice that includes:

(i) a description of its decision;

(ii) a description of the specific reasons for the decision;

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claimant's claim for benefits;

(v) a statement describing the Claimant's right to bring an action for judicial review under ERISA &502(a);

(vi) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(vii) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary, the period for making the determination will be "frozen" from the date the notification requesting the additional information is sent to the Claimant until the day the Claimant responds.

Plan's Failure to Follow Procedures

If the Plan fails to follow the claims procedures described above, a Claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Insured Benefits and State Law

With respect to any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supercede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations For Plan Claims

Please note that no legal action my be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

VI. CONTINUATION OF COVERAGE

6.1 Continuation Coverage. All notices and procedures for providing continuation of health coverage under the Plan to the extent required by applicable law will be determined under the applicable Summary Plan Description.

VII. FUNDING POLICY

7.1 Funded Trust. Employer's payments from the Plan will be provided out of the trust fund under the Trust Agreement between Employer and Trustee or Trustees.

VIII. COMPLIANCE WITH PRIVACY STANDARDS

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as

defined below). Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access in accordance with the following standards:

8.1 General. The Plan shall not disclose Protected Health Information to any member of Employer's workforce unless each of the conditions set out in this Amendment are met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

8.2 Permitted Uses and Disclosures. Protected Health Information disclosed to members of Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

8.3 Authorized Employees. The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated on Schedule I hereto and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. For purposes of this Amendment, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

a. Updates Required. The Employer shall amend Schedule I promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

b. Use And Disclosure Restricted. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

c. Resolution of issues of noncompliance. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Amendment and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

(1) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately;

whether there is a pattern of breaches; and the degree of harm caused by the breach;

(2) Appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(3) Mitigation of any harm caused by the breach, to the extent practicable; and

(4) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

8.4 Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

a. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

d. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;

e. Make available Protected Health Information to individual Plan members in accordance with § 164.524 of the Privacy Standards;

f. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with § 164.526 of the Privacy Standards;

g. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with § 164.528 of the Privacy Standards;

h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

i. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

j. Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by § 164.504(f)(2)(iii) of the Privacy Standards and set out in Section 8.3 hereof.

8.5 Privacy Notice. The Plan will comply with the applicable requirements of the Privacy Notice issued by the Plan pursuant to the requirements of the Privacy Standards and the Plan's Privacy Notice is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Plan as of the effective date of each revision without the need for further amendment of the Plan.

8.6 Security Standards. This section is effective as of April 20, 2006 Beginning on that date, the Plan will comply with all applicable requirements of the Security Standards, as provided in this Article and in the Security Standards and as interpreted pursuant to any authoritative guidance issued by the Department of Health and Human Services. If three is any conflict between the requirements of the Security Standards and any provision of this Plan, the Security Standards will control. Also, and amendment or revision or authoritative interpretation of the Security Standards is incorporated into the Plan as of the effective date of the guidance.

In addition, the Employer, by adopting this document, certifies that, beginning on the date this section becomes effective, the Employer will:

a. Reasonably and appropriately safeguard electronic Protected Health Information created, received, maintained, or transmitted to or by the Employer on behalf of the Plan;
b. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;
c. Ensure that the adequate separation required by Section 164.504(f)(2)(iii) of the Privacy Standards is supported by the reasonable and appropriate security measures;
d. Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect that information; and
e. Report to the Plan any security incident (occurring on or after the date this section becomes effective) of which it becomes aware.

IX. AMENDMENT AND TERMINATION

9.1 Employer Right to Amend or Terminate. Employer reserves the right to amend or terminate in whole or in part any or all of the provisions of this Plan, by delivering to Employees written notice of termination, provided that the amendment or termination is permissible under applicable law and the amendment or termination will not affect a claimant's rights to benefits with respect to reimbursable expenses that have been incurred prior to the date Employer action is taken to terminate the Plan or the effective date of such termination, whichever occurs last. Such amendment or termination shall be made by a party authorized to act on behalf of Employer, which action shall be written. No amendment to the Plan will change any term or condition of any other

related document included in the Adoption Agreement without the written consent of TPA.

9.2 Mandatory Amendments. Notwithstanding the provisions of this Article, or of any other provisions of this Plan, any amendment may be made, retroactively if necessary, which Employer or Third Party Administrator deems necessary or appropriate to conform this Plan to, or satisfy the conditions of, any law, government regulation or ruling, and to permit this Plan to meet the requirements of applicable law.

9.3 Reduction or Termination of Benefits. Participants in the Plan, including future retirees and retirees who have already retired, if any, have no right to Plan benefits after a Plan termination or a partial Plan termination affecting them, and have no right to Plan benefits to the extent that they are eliminated or reduced by a Plan amendment, except that such Participants are entitled to benefits with respect to covered events giving rise to benefits and occurring before the effective date of the Plan termination or applicable Plan amendment.

X. MISCELLANEOUS

10.1 Participant's Rights. Neither the establishment of this Plan, nor any modification of it, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against Employer or any of its officers, employees or agents, except as provided in this Plan. Under no circumstances will the terms of employment for any Participant be modified or in any way affected by this Plan. Nothing contained in this Plan shall be construed as a contract of employment between the Employer and any employee, or as a right of any employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its employees with or without cause.

10.2 Governing Law. Subject to ERISA or other applicable federal law, this Plan will be construed under the laws of the State of Baltimore.

10.3 Binding on All Parties. Any final judgment which is not appealed or appealable that may be entered in any legal action or proceeding will be binding and conclusive on the parties to that action or proceeding, Employer, and all persons having or claiming to have an interest under this Plan.

10.4 Headings. The headings of this Plan are inserted for convenience of reference only, and are not to be considered in the construction or the interpretation of this Plan.

10.5 Severability of Provisions. If any provision of this Plan is held to be invalid or unenforceable, that invalidity or unenforceability will not affect any other provision, and this Plan will be construed and enforced as if that provision had not been included.

10.6 Nonassignability. No Benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No Benefit under the Plan shall in any

manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for Plan coverage for an Alternate Recipient, in the manner described in ERISA §609(a) and in the Plan's QMCSO Procedures.

10.7 Construction of Terms. All terms in the Plan include the feminine and neuter genders and all references to the plural include the singular and vice versa, as appropriate. This Plan is to be interpreted so as to be consistent in all respects with the requirements of the Code and ERISA.

10.8 Integration of Plan Document. This Health and Welfare Plan document, the SPD and the related Adoption Agreement and its attachments contain all of the operative provision of this plan. Any conflict between the provisions of those documents and any other Employer document purporting to explain the rights, benefits or obligations under the Plan will be resolved in favor of this Plan document.

10.9 Payments to Incompetents. If the Employer knows that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, age or some other cause, it may cause all payments thereafter becoming due to such person to be made to the person's legal guardian for the person's benefit without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Employer.

10.10 Inability to Locate Recipient. If the Employer is unable to make a payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person (including notice of the payment so due mailed to the last known address of such Participant or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited eighteen months after the date such payment first became due or after such period as is provided in the applicable insurance contract.

10.11 Plan Communications. All communications in connection with the Plan made by a Participant shall become effective only when duly executed on forms provided by and filed with the Employer.

10.12 Source of Benefits. The Employer (and any insurance contracts purchased or held by the Employer) shall be the sole source of benefits under the Plan. No Employee or other person shall have any right to, or interest in, any assets of the Employer upon termination of the employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or other person.

10.13 Medicare and Medicaid Secondary Payor Rules. The Plan at all Times will be operated in accordance with any applicable Medicare and Medicaid secondary payor and non-discrimination rules, including, but not limited to the rules of §1144(a) of the Social Security Act. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over, and rules concerning working disabled individuals.

10.14 Non-Discrimination and Other Rules. All benefits and elections under this Plan shall be subject to all applicable law (e.g., the non-discrimination rules of Code

§§105(h), 125, 129 and 79, the Code §125 key employee 25% concentration rules, the Americans with Disabilities Act rules, etc.) and the Employer shall test the Plan for compliance with such rules and may take any actions it considers advisable for the purpose of ensuring the Plan's compliance with such rules.

10.15 Healthcare Continuation Coverage Rules. Notwithstanding any provision of the plan to the contrary, the Employer shall provide Participants and Dependents (as defined in the SPD) with all healthcare continuation coverage rights to which they are entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 and any other similar, applicable State Law.

10.16 HIPPA Rules. Notwithstanding any provisions of the Plan to the contrary, the Plan shall be administered at all times in accordance with the preexisting condition limitation, creditable coverage, certificate of coverage delivery, special enrollment period, notification, administrative simplification and other applicable requirements of the Health Insurance Portability and accountability Act of 1996.

10.17 Statute of Limitations. Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than twelve (12) months after the final review decision by the Employer has been rendered (or deemed rendered).

10.18 Coordination of Benefits. The coordination of benefits provisions specified in the SPD, as interpreted by the Employer in its discretion, shall control coordination of benefits situations involving the Plan and other payors.

10.19 Healthcare Integrity and Protection Data Bank. To the extent required by § 221(a) of the Health Insurance Portability and Accountability Act of 1996 (as codified at 42 U.S.C. §1320a-7e) and applicable regulations, the Plan will report any "final adverse action" (as described under those regulations) taken on behalf of a group health plan offerd under the Plan to the Healthcare Integrity and Protection Data Bank.

EXHIBIT 2C

EXHIBIT 'A'
TO
ADOPTION AGREEMENT

FEE SCHEDULE
FOR
THE HEALTH & WELFARE PLAN
OF
THE CHIMES, D.C., INC.

Health & Welfare Plan

The following fees are based on total contributions due to the Trust, in accordance with Article 2.1 of the Trust agreement, Section 1.2 of the Plan agreement and Article II of the TPA agreement. In the event FCE or Trustee is requested or required to provide or produce information or materials other than that described herein, FCE and/or Trustee shall be entitled to reimbursement from the Trust for the reasonable costs associated with providing and producing such information and materials, including but not limited to copying, printing, postage and professional time.

A. Claims Administration

Fee continues for 4 months after an employee's benefits under the plan terminate. The following table schedules the per-employee-per-month (pepm) fee charged to the trust for Claims Administration. The pepm fee decreases at each incremental increase in the "Employees" column

Claims & Termination

Employees	*Fee*
Under 500	$15.00
501-999	$13.50
1000- up	$11.75

B. Plan Management /Eligibility Administration

Insofar as contributions are due in accordance with Article II of the Third Party Administrator Agreement, attached as Exhibit B, in the event contributions are not received in a timely manner the Plan Management/Eligibility Administration fee shall be assessed at $30.00 per participant per month to be adjusted to the actual amount due when contributions and/or supporting documents are received. The following table schedules the fee charged to total contributions due from employer. The fee decreases at each incremental increase in the "Employees" column.

	Plan Management
Employees	*Fee*
Under 500	13.0%
501-999	12.0%
1000- up	10.0%

C. Plan Representation Services.....7.5%

Insofar as contributions are due in accordance with Article II of the Third Party Administrator Agreement, attached as Exhibit B,, in the event contributions are not received in a timely manner the Site Administration Services fee shall be assessed at $20.00 per participant per month to be adjusted to the actual amount due when contributions and/or supporting documents are received. The above stated fee is charged to total health contributions due from employer.

D. Trustee Services

For services provided by the Trustee as set forth in Article V of the Trust Agreement. Insofar as contributions are due in accordance with Article II of the Third Party Administrator Agreement, attached as Exhibit B, in the event contributions are not received in a timely manner the Trustee Services fee shall be assessed at $5.00 per participant per month to be adjusted to the actual amount due when contributions are received. The following table schedules the fee charged to total contributions due from employer. The fee decreases at each incremental increase in the "Employees" column.

	Trustee
Employees	*Fee*
Under 500	2.00%
501-999	1.95%
1000- up	1.90%

Dismissal Wage/Unemployment Benefit Plan

In the event your Plan includes the Dismissal Wage/Unemployment Benefit (DUB), the following fees and budgeted expenses are applicable:

A. Monthly Administration ..... $3.50 PEPM
$3.00 pepm charged to Employee's DUB Account
$0.50 pepm charged to The Chimes Health & Welfare Plan

For work done at FCE, California, tracking contributions per employee per month, paying for death benefit, posting earnings, and preparation of annual accountings for employees.

B. Annual Budgeted Expense ..... $0.85 PEPM
$0.85 pepm charged to The Chimes Health & Welfare Plan
For work done at FCE, California and by independent accountant/auditor performing annual audit and preparing and filing annual tax return for DUB trust. This is not a fee.

C. Termination Fee ..... $10.00 per employee
For work done at FCE, California, obtaining verification of termination of employer, preparation of benefit election materials for employee, processing termination, distribution of benefit, preparation and filing of all required tax documents including W-2s, 941s and 940s.

Disclosure

"FCE Benefit Administrators, Inc. and/or Steve Porter and Gary Beckman may receive commissions and/or administrative fees from insurance companies and benefit providers for services provided by FCE to this Plan. Whether any commissions and/or fees are received, as well as the actual amount received, if any varies from time to time and in accordance with benefit design changes.

Plan/Trust/TPA Agreement Termination

Special services will be required upon the termination of a Plan. These include preparation of final form 5500 and all other necessary tax reporting documents. Independent accounting/auditing fees will be charged at cost. "Claims administration fees will be charged at the same rates set forth in this Exhibit for run-out claims processing for up to four months after termination of the Plan. Run-out claims processing after that date will be provided as agreed between Chimes and FCE Benefit Administrators, Inc. Trustees' fee will be charged at $2.00 per participant per month for any run-out period."In the event any then existing asset is distributed to the participants in cash, a dispensing fee of $8.00 per participant will be charged for a single fringe rate and $15.00 per participant will be charged for multiple fringe rates. Services shall be provided by the parties named in this agreement from year to year at the rates set forth herein unless modified by the parties in writing at least 60 days prior to the anniversary date of effective coverage under this Plan and Trust.

EXHIBIT 2D

AMENDMENT TO THE ADOPTION AGREEMENT

FOR

THIS CHIMES, DC, INC.

HEALTH & WELFARE PLAN

This Amendment to the Adoption Agreement for The Chimes, DC, Inc. Health & Welfare Plan is made effective as of May 18, 2012 by and between The Chimes, DC, Inc. ("Employer") and FCE Benefit Administrators, Inc. ("Third Party Administrator").

WHEREAS, Section 5 reserves to both the Employer and FCE the authority to amend the Adoption Agreement; and

WHEREAS, the Employer now desires to amend the Adoption Agreement; and

NOW, THEREFORE, the Adoption Agreement (and all related Exhibits), is amended by Employer as set forth below:

Exhibit 'A' to the Adoption Agreement, Fee Schedule for the Health & Welfare Plan, shall be amended to add the following section: E. HRA Card Claims and Account Administration

E. HRA Card Claims and Account Administration

HRA Card Administration Fee PEPM	$6.50

IN WITNESS WHEREOF: the Employer acknowledges receipt of the information disclosed and approves the proposed transaction, and has executed this Amendment to the Adoption Agreement as Amended Exhibit 'A' to the Adoption Agreement, Fee Schedule for the Health & Welfare Plan this 18th day of May, 2012, to be effective May 18, 2012. This modification to the Fee Schedule exhibit of the Adoption Agreement is the only change to the current Adoption Agreement contemplated by this amendment.

EMPLOYER/PLAN SPONSOR/PLAN ADMINISTRATOR

THE CHIMES, DC, INC.

By: _____

Albert Bussone
Vice President
Chief Development Officer

THIRD PARTY ADMINISTRATOR

FCE BENEFIT ADMINISTRATORS, INC.

By: _____

Gary Beckman
President/CEO

EXHIBIT 2E

EXHIBIT 'B'
TO
ADOPTION AGREEMENT
FOR
THE CHIMES, D.C., INC.

THIRD PARTY ADMINISTRATOR AGREEMENT

THIS AGREEMENT is made by and between The Chimes, D.C., Inc. ("Employer") and FCE Benefit Administrators, Inc. ("TPA") each of which is more fully described in the Adoption Agreement of which this agreement is a part.

ARTICLE I
DEFINITIONS

The capitalized terms, words and phrases used in this Agreement will have the same meaning as those terms, words and phrases as defined in the Plan.

ARTICLE II
DUTIES OF EMPLOYER

(a) Employer Contributions. Employer shall make Contributions to the Trust for all Employees covered under the Plan.

(b) Employer Records. Employer shall provide to TPA all Earned Hours Records for each Employer Contribution. Alternatively, if contributions are paid as a monthly lump sum, Employer shall provide notice of all new hires who shall become Plan participants, and terminees who were Plan participants, monthly. The contribution rate structure/benefit design for Plan participants has been actuarially determined based on the assumption that all Employees within a specified group will participate in the Plan. If all Employees within a specified group do not participate in the Plan, Employer must inform TPA in writing timely and the contribution rate structure/benefit design for the group may be revised to minimize any potential negative effect on the Plan as a result of adverse selection. TPA reserves the right to request proof of participation by all Employees within a specified group.

(c) Contribution Due Date. The Employer shall be solely responsible for the accuracy of all Employer Contributions and related Earned Hours Records, and shall transmit them to TPA to be received by TPA no later than the 10th day of the month following the month for which the Fringe Benefit Amounts were earned. Alternatively, if contributions are paid as monthly invoiced amounts, contributions shall be received by the TPA no later than the 15th of the month for which coverage is effective. The Employer shall provide the TPA

with notice of any newly eligible employee prior to affected employee's coverage date, but no later than the last day of the month in which such newly hired employee becomes eligible for coverage. The Employer shall provide the TPA with notice of any terminated participant as soon as practicable but in no event later than required by applicable law.

(d) Penalty for Late Contributions and Return of Excess Contributions. If any Contribution becomes more than three months delinquent, then the TPA or Trustee may charge a delinquency penalty equal to the interest rate that the Money Market account would earn if contributions were not delinquent. If Employer makes a contribution in excess of the total Contribution required by the due date under II(c) above, then TPA shall inform the Employer of the amount of excess as soon as practicable, and Employer may request a refund from the Trustee as soon as practicable.

(e) Failure to Provide Information. In the event that a covered participant's employment has terminated, and as a result of the Employer's failure to provide the information required under II(c) above, the TPA or trustee has authorized and/or paid for benefits for such participant after the date on which such participant's coverage under the Plan should have terminated; or, a newly eligible employee has become effective for coverage under the Plan, but because the Employer has failed to provide the information required under II(c) above, the TPA or trustee has failed to authorize or pay for benefits for such newly eligible employee: all cost, liability and expense associated with such coverage, or the failure to provide such coverage, shall be borne by the Employer.

(f) Suspension of Benefits for Failure to Provide Contributions. If Employer fails to make the total Contribution required by the due date under II(c) above, then TPA will at any time have the right, in its sole discretion, to suspend payment of any or all benefits under the Plan incurred after the last month for which Contributions were made until Contributions are brought current, and TPA may notify all Employees affected by that suspension.

(g) Approval of Design of Benefits. The TPA shall be responsible for designing the benefits under the Plan, subject to Employer authorization and approval, and shall present such design of benefits to the Employer. The TPA shall have the duty, authority and responsibility to recommend, and the Employer shall authorize and approve, the increase, decrease, addition or deletion of Plan benefits under certain conditions or circumstances. Those conditions or circumstances include but are not limited to:

1. a substantial change in employee hours and/or contributions;
2. an unexpected, unplanned benefit utilization of the Plan;
3. a change in reserve requirements;
4. a substantial change in the cost to administer the Plan or in the cost of reinsurance or other expenses properly chargeable to the Plan; or
5. a change in the location of the service contract(s).

Modifications of Plan benefits shall take effect upon thirty (30) days prior written notice by the Plan Administrator to all Participants and beneficiaries affected by such modification. The Employer shall have the power in its sole and absolute discretion to determine when Plan benefit modifications are required.

(h) Dispositions of Unallocated Asset. In addition to its other rights and obligations hereunder, the Plan Administrator shall have the authority, from time to time, to establish guidelines for the disposition of unallocated asset, as hereinafter defined, to provide additional benefits to Participants and beneficiaries hereunder, either for the balance of the then current Plan Year, or for a shorter period thereof. For purposes hereof, "unallocated asset" shall mean funds held in this Trust that are in excess of the following amounts paid or required to be retained by the Trust:

1. claims;
2. insurance premiums;
3. plan expenses;
4. Aggregate Deductible or Hold Back Amounts, as those terms are defined in the stop loss insurance policies owned by the Plan;
5. prepaid contributions/run out liability; and
6. necessary trust operating capital.

In exercising its authority to establish guidelines for the disposition of unallocated asset to provide additional benefits hereunder, either for the balance of the then current Plan Year, or for a shorter period thereof, the Plan Administrator shall not exercise its discretion in a discriminatory manner. In the event that the Plan Administrator adopts guidelines for the disposition of unallocated asset to provide additional benefits hereunder, the Plan Administrator shall provide the Participants and beneficiaries under the Plan with written notice of such additional benefits, and a reasonable period of time within which to submit a claim for payment of such benefits. In addition, the Plan Administrator shall provide the Trustee and the TPA with written notice of such guidelines, as well as with written directions to pay such benefits, in such amounts, for claims incurred during such period(s) of time, and upon such terms and conditions as the Plan Administrator may designate, and any other guidance necessary and appropriate in order to implement such guidelines and provide such additional benefits.

ARTICLE III
DUTIES OF EMPLOYER DELEGATED TO TPA

(a) Duties Delegated to TPA. The Employer as Plan Administrator shall have the following additional duties, authorities and responsibilities, but such duties, authorities and responsibilities shall be delegated to TPA:

1. To administer claims for benefits under the Plan;
2. To prepare, sign, and file any and all reports to and tax returns for governmental authorities and disclosures to Employees required under applicable law for the Plan and Trust based on Earned Hour Records and other information provided by Employer or Plan Administrator;
3. To keep on Employer's behalf all books of account, records and other data necessary to administer the Plan on Employer's behalf and to meet the reporting and disclosure requirements of applicable law; and
4. Prepare and submit aggregate reports concerning paid claims to the reinsurance or stop loss carrier engaged by the TPA upon the approval of Employer, in accordance with the terms of such agreement.

ARTICLE IV
SERVICES OF THIRD PARTY ADMINISTRATOR

Except as specifically authorized in this Agreement, TPA will act in all matters only on the express written direction of the Employer.

(a) Claims Administration: Services include, to the extent applicable to the Plan:

1. accepting and receiving all requests for benefit payments under the Plan;
2. determining the entitlement to Plan benefits for each request made for benefits under the terms of the Plan and under cost control standards and procedures and practices set forth in the applicable managed care contracts;
3. approving, processing and paying medical, prescription, dental, vision, short term disability, and death claims;
4. giving written notice to any person of any denial of benefits after a request has been made and the rights of appeal of that denial, each in a

manner agreed to between Employer and TPA and which complies with the claims procedure requirements of Section 503 of ERISA;

5. preparing and transmitting a copy of the Explanation of Benefits (EOB) to participants for each processed claim;
6. preparing and transmitting daily data transfer to outside prescription drug card provider;
7. coordinating with PPO Network providers and UR/UM service providers;
8. preparing and transmitting participant ID Cards;
9. coordinating benefits between TPA plans and other benefit plans;
10. identifying and describing benefits to providers;
11. explaining benefits to participants and their advocates;
12. processing and paying Medicaid, Medicare, Champus and Tricare reimbursement demands;
13. administering and collecting subrogation and other third party obligations; and
14. monitoring, identifying, preparing, filing, and recovering stop loss obligations.

If an appeal is requested, TPA will conduct the review in accordance with final regulations issued by the Department of Labor and published in the Federal Register on November 21, 2000 and codified at 29 C.F.R. section 2560.503-1 and TPA will either (i) render a decision in accordance with the Plan SPD or (ii) refer the appeal to the Employer for a decision. Employer will have the discretionary authority to make the final decision on entitlement to Plan benefits for any request.

TPA will be responsible for making decisions on claims for benefits and will follow and enforce the Plan as written.

(b) Plan Management: Services include, to the extent applicable to the Plan:

1. designing initial benefit Schedules, preparing the Plan document, SPD and administrative forms, including COBRA notices;
2. tracking benefit use and subsequent design modifications;
3. preparing and disseminating specimen documents;
4. preparing and disseminating loss ratio reports, proposals, illustrations, certificates, booklets and policies;
5. establishing and maintaining insurance and reinsurance coverage for plans; and
6. conducting ongoing coordination with insurance and reinsurance underwriters.

(c) Eligibility/Compliance Administration: Services include, to the extent applicable to the Plan:

1. reconciling contributions and benefit coverage appropriate to employee's work schedule to earned hours payroll record as required by regulating Contracting Agency;
2. updating the participant database each payroll period with each employee's fringe qualified earned hours;
3. distributing all COBRA notices and processing new hire enrollment information and Employee termination/COBRA information; and
4. preparation and transmission of HIPAA Certificate of Creditable Coverage.

(d) Disposition of Unallocated Asset. Services include, to the extent applicable to the Plan, establishing guidelines for the disposition of unallocated assets, as hereinafter defined, to provide additional benefits to Participants and beneficiaries hereunder, either for the balance of the then current Plan Year, or for a shorter period thereof. For purposes hereof, "unallocated assets" shall mean funds held in this Trust that are in excess of the following amounts paid or required to be retained by the Trust:

1. claims;
2. insurance premiums;
3. plan expenses;
4. Aggregate Deductible or Hold Back Amounts, as those terms are defined in the stop loss insurance policies owned by the Plan;
5. prepaid contributions/run out liability; and
6. necessary trust operating capital.

In establishing guidelines for the disposition of unallocated assets to provide additional benefits hereunder, either for the balance of the then current Plan Year, or for a shorter period thereof, the TPA shall not do so in a discriminatory manner. In the event that the TPA adopts guidelines for the disposition of unallocated assets to provide additional benefits hereunder, the TPA shall provide the Participants and beneficiaries under the Plan with written notice of such additional benefits, and a reasonable period of time within which to submit a claim for payment of such benefits. In addition, the TPA shall provide the Trustee with written notice of such guidelines, as well as with written directions to pay such benefits, in such amounts, for claims incurred during such period(s) of time, and upon such terms and conditions as the TPA may designate, and any other guidance necessary and appropriate in order to implement such guidelines and provide such additional benefits.

(e) Plan Representative Services: Services to be provided by Benefit Consulting Group. Services include, to the extent applicable to the Plan:

1. site visits to explain benefits and enroll initial participant group;
2. facilitation of information necessary to obtain and disseminate employee ID cards;

3. completion of New Group Information form for each covered contract site and timely updates to same reflecting changes in contributions, contact personnel, contact information and the like;
4. periodic site revisits to repeat the benefit enrollment and presentation process due to employee and management turnover;
5. meetings on behalf of the employer, plan, or both with government agencies, collective bargaining representatives, in-house and outside legal counsel, and the like;
6. telephonic and personal accessibility to aid and assist employees and managers to understand and use the benefit plan;
7. transmittal of employee communication forms and documents;
8. interfacing between employer and plan participants to facilitate plan related communication and resolve issues;
9. employee advocacy on claims coverage issues; and
10. general on-site trouble shooting.

(f) Independent Legal Advice: TPA will not provide legal or tax advice to Employer and Employer understands and confirms that TPA has advised it to seek the advice of independent legal, tax, accounting or other advisor if Employer has any questions about the Plan, Trust, SPD or terms and conditions for services by TPA as third party administrator.

ARTICLE V
COVENANTS OF EMPLOYER

(a) Payment of Administrative Fees: Employer authorizes the payment to TPA and/or other named service providers of the administrative charges specified in the Fee Schedule described in Exhibit 'A' of the Adoption Agreement.

(b) Primary Responsibility: The Employer will be the Plan Administrator and, except as specifically limited by this Agreement, will have exclusive authority and responsibility for the Plan, its operation and compliance with applicable law.

(c) Furnish Necessary Information: Employer will furnish to TPA all Employee, Participant and Dependent information necessary to determine eligibility for benefits under the Plan. Employer will also provide TPA with information about events affecting Employees, Participants and their Dependents, which would entitle them to a notice of rights to continuation of health benefits under the Plans under COBRA. If TPA has actual knowledge of information necessary to determine Employee, Participant or Dependent eligibility for benefits under the Plan or entitlement to COBRA rights, information will be deemed to have been furnished by Employer, except to the extent required by applicable law.

(d) Indemnity by Employer: Employer hereby agrees to indemnify, hold harmless and assume the defense of TPA, its directors, shareholders, officers, employees, agents and attorneys ("TPA Parties") from or against any claim, liability, loss, damage, fine, penalties

and costs, including reasonable attorney's fees, ("Claims") which any TPA Party may incur to the extent that Claim is caused by (a) any failure of Employer to comply with any covenant or obligation of Employer under this Agreement, the Plan or Trust or (b) any misrepresentation or breach of warranty by Employer under this Agreement, the Plan or Trust. If Employer fails to do so, TPA may compromise and settle or defend against any Claim, and Employer will be obligated to indemnify and hold harmless TPA for all costs of defense, compromise and settlement, including any judgments incurred by or rendered against TPA, which arise out of the Claim. The provisions of this Section will survive the termination of this Agreement and the Plan.

(e) Withholding: Employer will comply with applicable federal and State income and payroll withholding laws for fringe benefit contributions and employee wage deductions. Unless otherwise notified in writing by Employer, TPA is authorized by Employer to assume that each recipient of benefits under the Plan is a resident of the United States or if not a resident is a United States citizen.

ARTICLE VI
COVENANTS OF TPA

(a) Professional Liability Insurance: TPA will maintain professional errors and omissions insurance in amounts consistent with and customary for an administrator of its size.

(b) Standard of Care: TPA will use the same care and skill as a similarly situated provider of similar services would exercise following commonly accepted industry and third party administrator practices in the provision of administrative services for the Plans.

(c) Continuing Liability of Employer and Trustee: Neither this nor any other agreement will relieve Employer or other designated fiduciaries, including any Trustee, of any of the responsibilities or liabilities imposed by ERISA.

(d) Reliance on Employer: TPA will rely for its performance of its services under this Agreement on the information submitted to it by Employer. TPA is not responsible for any penalties, sanctions, taxes or any other liability due to the failure of Employer to submit accurate information to TPA on a timely basis.

(e) No Liability for Acts of Prior Administrator. TPA will not be liable or responsible for anything done or omitted in the administration of the Plan prior to the Effective Date, nor, except on Employer's written direction, will TPA be required to inquire into or take any action concerning the acts of any prior administrator.

(f) Indemnity by TPA. TPA hereby agrees to indemnify, hold harmless and assume the defense of Employer, its directors, officers, employees, agents and attorneys ("Employer Parties") from or against any claim, liability, loss, damage, fine, penalties and costs, including reasonable attorney's fees ("Claims") which any Employer Party may incur to the extent that Claim is caused by (a) any failure of TPA to comply with any covenant or obligation of TPA under this Agreement, the Plan or Trust or (b) any misrepresentation or breach of warranty by TPA under this Agreement, the Plan or Trust. If TPA fails to do so, Employer may compromise and settle or defend against any Claim, and TPA will be obligated to indemnify and hold harmless Employer for all costs of defense, compromise and settlement, including any judgments incurred by or rendered against Employer which arise out of the Claim. The provisions of this Section will survive the termination of this Agreement and the Plan.

ARTICLE VII
AMENDMENT AND TERMINATION

(a) Amendment: No amendments to this Agreement will be binding unless executed in writing by TPA and Employer, and no change in any Service Provider to the Plan and Trust will be effective unless approved in writing by both TPA and Employer.

(b) Term: The term of this Agreement will begin on the effective date of this Agreement and end when terminated by either party on 60 days' prior written notice to the other party.

(c) Responsibilities on Termination: On any termination of this Agreement, TPA will complete the processing of all requests for benefit payments under the Plan which are received by TPA prior to the effective date of termination except TPA will not be obligated to process benefit payment requests if Employer fails to fund benefit payments until all funds requested by TPA have been furnished.

ARTICLE VIII
MISCELLANEOUS

(a) Captions: The captions and headings of the Sections and subsections of this Agreement are for convenience of reference only and are not to be used in the interpretation of this Agreement.

(b) Late COBRA Notification: While all parties will make every effort to make sure that information is timely transmitted regarding employee terminations and that COBRA election notices are timely sent, in the event that a COBRA election notice is not timely sent thereby resulting in a COBRA qualified beneficiary having the right to elect COBRA

coverage after the election period which would have applied if the COBRA election notice were timely sent, any party in interest to the Plan (Employer/Plan Sponsor, Plan Administrator, Third Party Administrator or Trustee) may upon discovery of such delay elect COBRA on behalf of the qualified beneficiary (if the period for doing so has not expired) and pay COBRA premium to the Plan on behalf of the qualified beneficiary from the date coverage under COBRA would have first been effective through a specified date, and the Plan shall be responsible for paying claims incurred during such time period.

(c) Additional Documents: Each party to this Agreement agrees to cooperate with the other in good faith and will, on demand, execute any other documents or instruments necessary or convenient to carry out the provisions and intent of this Agreement.

(d) Entire Agreement: This Agreement contains the entire agreement among the parties for the subject matter of it and supersedes all prior and contemporaneous oral and written agreements, understandings and representations among the parties.

(e) Attorneys' Fees and Costs: If any action in law or in equity, or any submission to arbitration, is necessary to enforce or interpret the terms of this Agreement, or the rights and duties of the parties, the prevailing party will be entitled, in addition to any other relief that may be granted, to recover all costs and expenses incurred in connection with that action, including reasonable attorneys' fees and costs.

(f) Governing Law and Venue: This Agreement will be governed by the internal laws of the State of California except to the extent preempted by ERISA, COBRA or other applicable federal law and the venue for resolving any dispute under this Agreement will be Baltimore County, Maryland.

(g) Assignment: Neither this Agreement nor any interest in it will be assignable by either party without the prior written consent of the other party.

(h) Successors and Assigns: Subject to any limit on assignment in this Agreement, this Agreement will inure to the benefit of and bind the respective successors in interest, assigns, heirs, and executors and administrators of the parties to this Agreement.

(i) Severability: If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions will nevertheless continue in full force and effect without being impaired or invalidated in any way.

(j) Survival of Representations: All representations, warranties, covenants, and agreements made in this Agreement by the parties will survive the closing of this transaction until satisfied in full.

(k) Construction: As required by the context of this Agreement, each pronoun and parenthetical reference and any defined terms will mean and be construed to include the singular and plural and the masculine, feminine and neuter.

(l) Waiver: No waiver of any of the provisions of this Agreement will be deemed or will constitute a waiver of any other provision, nor will any waiver constitute a continuing waiver. No waiver will be binding unless executed in writing by the party making the waiver.

(m) Notices: Any notice, payment or other communication required or permitted under this Agreement will be deemed effective when personally delivered or deposited in the United States mail, postage prepaid and addressed to Employer at the address provided in the Trust Agreement or to TPA at 887 Mitten Road, Suite #200, Burlingame, CA 94010-1303. Either party may change address for purposes of this Section by sending a notice of that changed address in accordance with this Section.

EMPLOYER:

The Chimes, DC, Inc.

By: _____
Name: Albert Bussone
Title: Vice President

TPA:

FCE Benefit Administrators, Inc.

By: _____
Name: Gary Beckman
Title: President, CEO

Benefit Consulting Group

By: _____
Name:
Title:

EXHIBIT 2F

EXHIBIT 'C'
TO
THE HEALTH AND WELFARE PLAN

PLAN SPONSOR CERTIFICATION
FOR
COMPLIANCE WITH PRIVACY STANDARDS

Employer Sponsor of the Plan certifies that the Plan is hereby amended to comply with the Standards for Privacy of Individually Identified Health Information (45 CFR Part 164, the "Privacy Standards").

The Chimes, DC, Inc.

Signature: _____

Name: Albert Bussone

Title: Vice President

Date: 3-15-04

SCHEDULE 'I'

Under this schedule, the Employer Sponsor of the Plan shall designate by job classification/title those members of the employer's workforce who are authorized to receive Protected Health Information to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan and have received appropriate training regarding the Plan's Health Information Privacy Policies and Procedures and the applicable requirements of the Privacy Regulations.

Job Classification/Title	
Albert Bussone Vice President/Chief Operating Officer	
Martin Lampner, CPA Chief Financial Officer	
Lee Anne Bussone Director, Human Resources Training & Compliance	
Karen Holcomb, Benefits Coordinator	

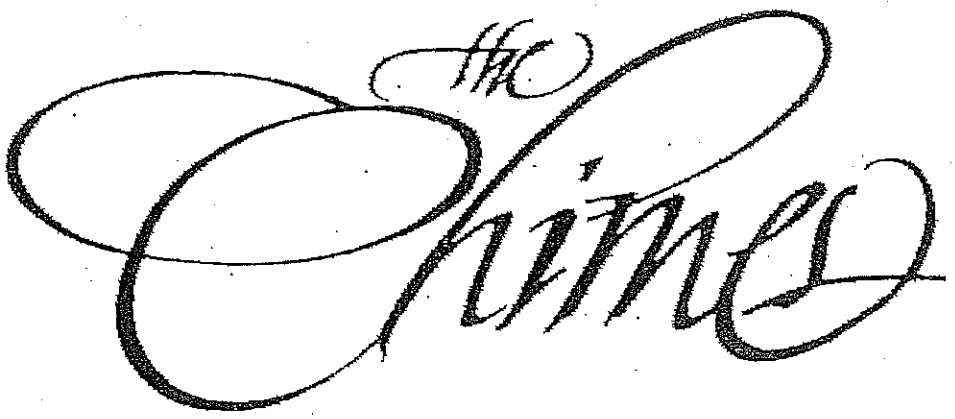
EXHIBIT 2G

Summary Plan Description Of Employee Welfare Benefits

Major Medical Benefits

&

Primary Care Plan



AN EMPLOYER FUNDED PLAN
STOP LOSS INSURED

Dear Participant:

We are proud to present to you this booklet, which describes The Chimes/DC Health and Welfare Plan of Benefits for your group. This booklet is a guide to your benefits.

You will receive a "Schedule" from your Employer, which lists all the benefits and the coverage provided according to your work schedule. The Schedule allows you to view your entire benefit plan at a glance and should answer most of your questions. Only those benefits listed on the Schedule are included in your plan.

This booklet serves to provide you with a more complete explanation of each benefit, as well as to acquaint you with certain important rights and protections provided in law.

FCE Benefit Administrators, Inc.
Claims Division
445 Recoleta, Suite 100
San Antonio, TX 78216-7520

210-349-9801

— or —
1 -800-899-WELL
1-800-899-9355

TTY Phone Number for
Hearing Impaired
1-877-319-7145

We look forward to serving your Health and Welfare needs and should you have any questions regarding the information above, or just questions in general, please do not hesitate to contact us.

Sincerely,

FCE Benefit Administrators, Inc.

HOW TO USE THIS BOOKLET

This booklet provides a detailed description of the benefits to which you, as a Chimes/DC Employee, and your eligible Dependents are entitled.

In order for you to use this document as readily and easily as possible, we recommend that you note certain simple things regarding its structure. This brief, introductory explanation is intended to assist you in this regard.

You will notice a tab that divides this document into two sections. The section preceding this tab is titled "Major Medical Benefits." The section following this tab is titled "Primary Care Plan." The section that applies to you as an eligible Employee will depend on the Employee Class to which you belong. Specifically, the applicability of these two sections is determined as follows:

1) If you are in Class I, II or III, then refer to the section titled "Primary Care Plan" (the second section) for a description of your benefits. You are in Class I, II or III if you were paid for an average of fewer than 31 hours weekly over the 13 weeks immediately preceding the date you incur a claim.

2) If you are in Class IV, then refer to the section titled "Major Medical" (the first section) for a description of your benefits. You are in Class IV if you were paid for an average of 31 hours or more weekly over the 13 weeks immediately preceding the date you incur a claim.

If you are uncertain as to your classification, please consult FCE's Customer Service Department at 1-800-899-9355.

For the purpose of using this booklet, your classification does not affect Dependent coverage. Regardless of which section applies to you, Dependent medical benefits are always described in the section titled "Primary Care Plan." The section titled "Major Medical Benefits" does not describe any aspect of Dependent medical benefits because Dependents are ineligible for Major Medical coverage.

Discussions of Dependent eligibility and enrollment under the Plan are confined to the section titled "Primary Care Plan." These discussions cross-apply to the section titled "Major Medical Benefits" only where non-medical benefits are addressed in this section. Dental and vision are examples of non-medical benefits.

Should have any questions concerning the applicability of any section, subsection or provision of this booklet, please contact us:

FCE Benefit Administrators
Claims Division
445 Recoleta, Suite 100
San Antonio, TX 78216-7520
1-800-899-9355

BENEFIT PLAN SUMMARY DESCRIPTION

This booklet has been prepared to furnish you with information regarding the benefits to which you and your eligible dependents are entitled under the Benefit Plan Program in which you have enrolled. The Employee Retirement Income Security Act of 1974, as amended (ERISA) requires that all participants be furnished a summary description of their benefit Plan. It has been our objective to describe the Plan clearly and directly; however, if you have any questions concerning the Plan or the information and provisions of this coverage, please consult FCE Benefit Administrators, Inc., the Third Party Administrator, Claims Division at 1-800-899-9355.

Name of Plan:	The Chimes, D. C., Inc. Health & Welfare Plan
Plan Number:	501
Plan Effective Date:	May 1, 1995
Plan Sponsor and Plan Administrator:	The Chimes, D. C., Inc. 4815 Seton Drive Baltimore, MD 21215 EIN #54-1691953
Third Party Administrator:	FCE Benefit Administrators, Inc. 887 Mitten Road, Suite 200 Burlingame, CA 94010 (800) 899-0306
Plan Trustees:	Marilyn A. Ward, Esq. 3615 Capistrano Trail Austin, TX 78739 Vivian Lewis, Esq. 184 Pine Avenue, #3 Pacific Grove, CA 93950
Agent for Service of Process	FCE Benefit Administrators, Inc. 887 Mitten Road, Suite 200 Burlingame, CA 94010-1303 (800) 899-0306 Attention: Steve Porter
Claims Department:	FCE Benefit Administrators, Inc. 445 Recoleta, Suite 100 San Antonio, TX 78216 (800)899-9355

Major Medical Benefits

TABLE OF CONTENTS

INTRODUCTION

This document is a description of Chimes/DC, Inc. Health and Welfare Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

Important Notice Concerning Dependent Coverage

Medical benefits for your eligible Dependents are described in the section of this booklet titled "Summary Plan Description of Employee Welfare Benefits – Limited Benefits" on page 3. The Major Medical benefits described in the present section of this booklet apply only to Employees eligible under Class IV of Chimes/DC, Inc. Health and Welfare Plan. Dependents are not covered under Major Medical benefits. However, eligible Dependents are covered under the benefits described in certain other sections:

- Supplementary Accident Charge Benefits (Page 16)
- Prescription Drug Benefits (Page 17)
- Vision Care Benefits (Page 20)
- Dental Benefits (Page 21)
- Dependent's Life Insurance Benefits (Page 30)
- Employee Assistance Program (Page 30)

Please refer to the Limited Benefits portion of this booklet for a discussion of Dependent eligibility and enrollment.

Document Summary

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Major Medical Benefits. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges. This section also provides guidance concerning the pre-certification procedures which help ensure the maximum level of reimbursement allowable under the Schedule for inpatient hospital admissions.

Supplementary Accident Charge Benefits, Prescription Drug Benefits, Vision Care Benefits, Dental Benefits, Continuation of Benefits During an Authorized Leave (CBDAL), Life Insurance Benefits, Accidental Death and Dismemberment, Your Beneficiary, Dependent's Life Insurance Benefits, Hearing Aid Benefit, Employee Assistance Program (EAP), Flu/Hepatitus B Vaccines and Dismissal / Unemployment Benefits (DUB). These consecutive sections describe a variety of benefits that are included in the Plan in addition to and apart from the Major Medical benefit.

Newborns and Mothers Health Protection Act and Woman's Health and Cancer Rights Act of 1998. These two consecutive sections summarize certain federally legislated rights retained by participants in the Plan.

Claim Procedures. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Responsibilities for Plan Administration. Explains the duties of the Plan Administrator and fiduciary.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

Eligibility

Eligible Classes of Employees. All Active Employees of the Employer for whom the Employer has made the requisite Contribution.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she has averaged at least 31 hours over a 13-week period (or appropriate shorter period) and is on the regular payroll of the Employer for that work.

(2) is in a class eligible for coverage.

(3) completes the employment Waiting Period as specified on the ScheduleA "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time.

Funding

Cost of the Plan. Chimes/DC pays the entire cost of coverage under this Plan. Benefits are paid from the trust that has been established to receive contributions from the Chimes/DC and to pay benefits due under the Plan.

Pre-existing Conditions

A Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician. (The Pre-Existing Condition does not apply to pregnancy.)

No benefits in excess of $5,000 will be payable under this Plan for a pre-existing condition unless the participant has been treatment free for 6 months from the effective date of coverage or until the participant has been covered by the Plan for 12 consecutive months unless the participant can demonstrate prior coverage under a comparable Plan at some time during the period commencing 63 days prior to the date the Employer first has a fringe benefit obligation for the participant.

The length of the Pre-Existing Condition Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan.

An eligible person may request a certificate of Creditable Coverage from his/her prior plan within 24 months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from the prior Plan.

A Covered Person will be provided a certificate of Creditable Coverage if he/she requests one either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred within 12 consecutive months after the person's Enrollment Date. This time may be offset if the person has Creditable Coverage from his/her previous plan.

Enrollment

In order to process your claims completely and assure the highest level of benefits possible, eligible Employees must enroll for coverage by filling out and signing an enrollment form and sending it to FCE Benefit Administrators through Chimes/DC.

Although FCE will issue ID cards and process most claims solely on the basis of payroll information received from Chimes/DC, the properly completed enrollment form is the only source we have that informs us about your chosen Beneficiary for the death benefit.

Participation in Chimes/DC, Inc. Health & Welfare Plan is mandatory.

Procedures Regarding Enrollment Forms

1. All enrollment forms should be signed and returned.
2. If a Contribution is made for the Employee, but no enrollment form is received, FCE will proceed as follows:
   a. Will verify benefits subject to eligibility.
   b. Will pay all allowable Employee claims.
   c. Will not deny a claim for eligibility reasons.
3. If an unsigned enrollment form is received, it will be returned. If other information is required as well, all information will be requested at the same time as the signature.

It is very important to keep your enrollment form updated. Report any important change at once to Chimes/DC Benefit Manager at 4815 Seton Drive, Baltimore, MD 21215 or fax the enrollment form to (410) 358-0031.

Effective Date

An Employee will be covered under this Plan as of the first day that the Employee satisfies al of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement. (An Employee must be an Active Employee a defined by this Plan for this coverage to take effect.)

(3) The Enrollment Requirements of the Plan.

Termination of Coverage

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

Your eligibility for benefits terminates when the Third Party Administrator stops receiving Contributions for your coverage. Contributions will cease if you leave the employment of your Employer, if your Employer fails to timely pay the required Contributions, and/or if the Plan is terminated. An Employee so situated will receive extended coverage equal to one month after Contributions to the Plan cease.

If you terminate employment or your Employer terminates Contributions on your behalf, prior to reaching your effective date of coverage, you will not be covered under the plan and your Employer paid Contributions will not be refunded.

You are required to turn in your insurance identification card to the Employer, or to FCE Benefit Administrators, at the time your coverage terminates. If you fail to do so and you use your insurance identification card after your coverage terminates, you will be responsible for all of the costs associated with such use. In addition, if you use your insurance identification card after your coverage terminates, such action constitutes fraud, and you may be liable for both civil and criminal penalties for such unauthorized use. Either FCE Benefit Administrators or your Employer, or both, will seek legal redress of such unauthorized use of your insurance identification card, to the maximum extent permitted.

Continuation During Family and Medical Leave. This Plan shall at all times comply with the Family and Medical Leave Act of 1993 (as promulgated in regulations issued by the Department of Labor) or with the regulations enforced in a local jurisdiction if such regulations are more expansive than FMLA.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period or Pre-Existing Conditions provision.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 18 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

Qualified Support Orders

The Plan recognizes Dependent child coverage as required under a Qualified Medical Child Support Order, a National Medical Support Notice or other appropriate court order, as determined by the Plan Administrator. The Plan also recognizes coverage as required under a Qualified Domestic Relations Order with respect to a former spouse. The Plan has procedures in place to qualify such orders or notices. If you have an order or notice requiring coverage of a child or former spouse under the Plan, you should contact the Plan Administrator immediately to determine whether the order or notice is qualified. You and your beneficiaries may obtain, without charge, a copy of these procedures from the Plan Administrator.

MAJOR MEDICAL BENEFITS

General Information

Verification of Eligibility FCE Benefit Administrators, Inc. 1-800-899-9355. Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

All benefits described in your Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: Non-emergency inpatient hospital admissions must be precertified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

The Plan is a plan which contains a Preferred Provider Organization (PPO).

PPO name: Alliance PPO/MAPSI
Address: P.O. Box 934
Frederick, MD 21705-0934
Telephone: 800-342-3289
Fax: 301-360-8905
E-mail: www.mamsi.com

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher in-Network payment will be made for certain non-Network services:

- If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.
- If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.
- If a Covered Person receives Physician or anesthesia services by a non-Network Provider at an in-Network facility.

In order to reimburse these otherwise non-network expenses at the higher in-Network levels, however, the Plan may find additional information useful. Please contact the Plan about the special circumstances noted above should any one of them ever apply to the delivery of your services.

Deductible Features

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule.

Deductible Three Month Carryover. Covered expenses incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

Copayment

A copayment is a smaller amount of money that is paid by the Employee each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue toward the 100% maximum out-of-pocket payment.

Benefit Payment

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule. No benefits will be paid in excess of the Maximum Benefit Amount or any limit specified on the Schedule.

Out-of-Pocket Limit

The Employee's payable share of expenses is required at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule is reached. Then, Covered Charges incurred by a Covered Person will be payable by the Plan at 100% for the rest of the Calendar Year.

Maximum Benefit Amount

The Maximum Benefit Amount is shown in the Schedule. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

Covered Charges

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and

board will be payable as shown in the Schedule. After 23 observation hours, a confinement will be considered an inpatient confinement.

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(3) **Extended Care Facility.** The room and board and nursing care furnished by an Extended Care Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility;

(b) the confinement starts immediately following a Hospital confinement or a period of Home Health Care Utilization;

(c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Extended Care Facility.

Covered charges for a Covered Person's care in these facilities is limited to the covered daily maximum shown in the Schedule. This benefit will not pay for special private duty nursing, telephone and television service or other non-medical services.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

(a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for a second procedure performed through the same incision; 45% of the Usual and Reasonable Charge will be allowed for a third procedure performed through the same incision. Any procedure that would not

be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Outpatient private duty nursing care is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Extended Care Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Local Medically Necessary professional land **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Extended Care Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(e) Initial **contact lenses** or glasses required following cataract surgery.

(f) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(g) **Laboratory studies.**

(h) Treatment of **Mental Disorders and Substance Abuse**. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(i) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(j) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(k) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

The maximum benefit for all transplant procedures performed during a Covered Person's lifetime is shown in the Schedule.

Benefit payments for transplant charges are included under the Organ Transplant Maximum Benefit Limit shown in the Schedule.

There is no coverage under the Plan for charges incurred in obtaining donor organs or tissues. This includes charges for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

(l) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(m) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(n) **Prescription** Drugs (as defined).

(o) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

(p) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(q) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(r) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

(s) **Sterilization** procedures.

(t) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(u) Diagnostic **x-rays.**

COST MANAGEMENT SERVICES

Precertification

Please refer to the Employee ID card for the Cost Management Services phone number.

Alliance PPO/MAPSI
1-800-342-3289 / 1-800-962-0643

The patient or the patient's representative must call this number to receive certification of inpatient hospital admissions.

Any reduced reimbursement due to failure to follow precertification procedures will not accrue toward the 100% maximum out-of-pocket payment.

Here's how the program works:

Before a Covered Person enters a Medical Care Facility on a non-emergency basis, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 48 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's representative, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the first $300 of covered charges incurred for each hospital admission for which precertification is required but not obtained will be excluded and not considered to be covered medical charges. Covered charges in excess of such excluded $300 amounts will be paid subject to the applicable deductible amount. However, the benefit percentages described in your schedule will be reduced by 20%. All such excluded charge and amounts, therefore, will not be used to satisfy any deductible amount or out-of-pocket limit of the plan.

Second and/or Third Opinion Program

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

Pre-admission Testing Service

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered charges for this testing will be payable at coinsurance levels indicated on your Schedule even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required. The deductible will also be waived for these tests.

SUPPLEMENTARY ACCIDENT CHARGE BENEFITS

This benefit applies when an accident charge is incurred for care and treatment of a Covered Person's Injury and:

(1) the Injury is sustained while the person is covered for these benefits; and

(2) the charge is for a service delivered within 24 hours of the date of the accident; and

(3) to the extent that the charge is not payable under any other benefits under the Plan (other than Medical Benefits).

Benefit Payment

Benefits will be paid as described in the Schedule.

Accident Charge

An accident charge is a Usual and Reasonable Charge incurred for the following:

(1) Physician services.

(2) Hospital care and treatment.

(3) Diagnostic x-rays and lab tests.

(4) Local professional ambulance service.

(5) Surgical dressings, splints and casts and other devices used in the reduction of fractures and dislocations.

(6) Nursing service.

(7) Anesthesia.

(8) Covered Prescription Drugs.

(9) Use of a Physician's office or clinic operating room.

(10) Dental.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Express Scripts, Inc. is the administrator of the pharmacy drug plan.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the Schedule. The copayment amount is not a covered charge under the medical plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the Schedule will be the ingredient cost and dispensing fee.

Percentages Payable

The percentage payable amount may apply to specialty drugs and injectables and is shown in the Schedule. This amount is not a covered charge under this Plan or the medical plan.

Calendar Year Maximum

The Calendar Year maximum is the maximum amount this Plan will pay for all covered medical expenses in one Calendar Year. Each January 1st, this amount renews.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, Express Scripts, Inc., the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

To enroll in the Mail Service Pharmacy and to place your initial order, you must fill out a Mail Service Pharmacy Enrollment Form. You may obtain these forms by calling Express Scripts at 1-800-451-6245 or enrolling online at www.express-scripts.com.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(9) **Immunization.** Immunization agents or biological sera.

(10) **Impotence.** A charge for impotence medication.

(11) **Infertility.** A charge for infertility medication.

(12) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for diabetic supplies).

(13) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

VISION CARE BENEFITS

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

Benefit Payment

Benefit payment for a Covered Person will be made as described in the Schedule.

Vision Care Charges

Vision care charges are the Usual and Reasonable Charges for the vision care services and supplies shown in the Schedule. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule for each vision care service or supply.

Limits

No benefits will be payable for the following:

(1) **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

(2) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

(3) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.

(4) **No prescription.** Charges for lenses ordered without a prescription.

(5) **Orthoptics.** Charges for orthoptics (eye muscle exercises).

(6) **Sunglasses.** Charges for safety goggles or sunglasses, including prescription type.

(7) **Training.** Charges for vision training or subnormal vision aids.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

Deductible

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule.

Benefit Payment

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule. No benefits will be paid in excess of the Maximum Benefit Amount.

Maximum Benefit Amount

The Maximum dental benefit amount is shown in the Schedule.

Dental Charges

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

Covered Dental Services

Class A Services:
Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each calendar years.

(2) Bitewing x-ray series.

(3) One full mouth x-ray every 36 months.

(4) Fluoride treatments for covered Dependent children.

(5) Space maintainers for covered Dependent children under age 14 to replace primary teeth.

(6) Emergency palliative treatment for pain.

(7) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 14, once per tooth in any 24 months.

Class B Services:
Basic Dental Procedures

(1) Dental x-rays not included in Class A.

(2) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.

(3) Periodontics (gum treatments).

(4) Endodontics (root canals).

(5) Extractions. This service includes local anesthesia and routine post-operative care.

(6) Recementing bridges, crowns or inlays.

(7) Fillings, other than gold.

(8) General anesthetics, upon demonstration of Medical Necessity.

(9) Antibiotic drugs.

Class C Services:
Major Dental Procedures

(1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Installation of crowns.

(3) Installing precision attachments for removable dentures.

(4) Addition of clasp or rest to existing partial removable dentures.

(5) Initial installation of fixed bridgework to replace one or more natural teeth.

(6) Repair of crowns, bridgework and removable dentures.

(7) Rebasing or relining of removable dentures.

(8) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:

(a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

(b) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 30 days from the date the temporary denture was installed.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

Exclusions

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Broken appointments.** Charges for broken or missed dental appointments.

(3) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(4) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

(5) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(6) **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

(7) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

(8) **No listing.** Services which are not included in the list of covered dental services.

(9) **Orthodontia.** Orthodontic treatment and orthognathic surgery.

(10) **Personalization.** Personalization of dentures.

(11) **Replacement.** Replacement of lost or stolen appliances.

(12) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

CONTINUATION OF BENEFITS DURING AN AUTHORIZED LEAVE (CBDAL)

The Plan will continue to cover you and your eligible dependents with health care benefits while you are prevented from working due to your serious health condition, the serious health condition of your spouse, child or parent. The CBDAL Benefit is also provided to care for your child after birth, or placement for adoption or foster care, provided that the disabling medical or family event occurs on or after the effective date of coverage. If the disability results from your serious health condition, you must be under the care of a legally qualified Physician and your disability must result from non-job related accident, sickness or disease for which benefits are not payable under any worker's compensation law. If the authorized leave results from the need to care for your seriously ill spouse, child or parent, medical certification will be required.

Eligibility for Benefits

You are eligible for this benefit if you have worked for Chimes/DC for at least one year and have worked 1,250 hours or the minimum number of hours as specified by your local jurisdiction regulations during the 12 months immediately previous to the authorized leave. Any Employee who is denied job-protected family medical leave is not eligible for this benefit.

Level of Coverage

The level of plan coverage during your disability is based on average fringe paid hours for the 13 week period immediately preceding your authorized leave.

Maximum Number of Weeks

The CBDAL Benefit has a Plan year maximum of 12 weeks, or the maximum number of weeks as specified by local jurisdiction regulations, of coverage per calendar year unless otherwise required by law.

LIFE INSURANCE BENEFITS

This benefit is fully insured through Reliance Standard Life Insurance Company (RSL).

Life Insurance Benefits are payable in the event of your death from covered causes:

1. While you are eligible for benefits.
2. Upon submission of an original Death Certificate.
3. Upon submission of a Police Report if one was prepared.

Conversion Privilege

You can use this privilege when your insurance is no longer in force. It has several parts. They are:

A. If the insurance ceases due to termination of employment or membership in any of the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within 90 days after you terminate. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:

- The policy will, at your option, be on any one of Reliance Standard Life's forms, except for term life insurance. It will be the standard type issued by Reliance Standard Life

Insurance Company for the age and amount applied for;
- The policy issued will be for an amount not over what you had before you terminated;
- The premium due for the policy will be at Reliance Standard Life's usual rate. This rate will be based on the amount of insurance, class of risk and your age at date of policy issue; and
- Proof of good health is not required.

B. If the insurance ceases due to the termination or amendment of the Policy, an individual Life Insurance Policy can be issued. You must have been insured for at least 5 years under the Policy. The same rules as in a above will be used except that the face amount will be the lesser of:

1. The amount of your Group Life benefit under the Policy. This amount will be less any amount you are entitled to under any other group life policy issued by Reliance Standard Life Insurance Company or another insurance company; or
2. $5,000.

C. If the insurance reduces, as may be provided in the Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.

D. If you die during the time in which you are entitled to apply for an individual policy, Reliance Standard Life Insurance Company will pay the benefit under the Group Policy that you were entitled to convert. This will be done whether or not you applied for the individual policy.

E. Any policy issued with respect to A, B, or C above will be put in force at the end of the 90 day period in which application must be made.

Continuation of Insurance

Your insurance may be continued by payment of the premium beyond the date you cease to be eligible for this insurance, but not longer than:

1. Twelve (12) months, if due to illness or injury; or
2. One (1) month, if due to temporary lay-off or approved leave of absence.

Reinstatement

Your insurance may be reinstated if it was terminated while you were:

1. on an approved leave of absence; or
2. on temporary lay-off.

You must return to active work within six (6) months. You must also be a member of a class eligible for this insurance.

You will not be required to fulfill the eligibility requirements of the Policy again. The insurance will go into effect on the day you return to active work. If you return after having resigned or having been discharged, you will be required to fulfill the eligibility requirements of the Policy again.

If you return after terminating at your own request or for failure to pay premium when due, proof of good health must be approved by Reliance Standard Life Insurance Company before you may be reinstated.

Accelerated Benefit Rider

This benefit is payable to the Insured if, after having been covered under this Rider for at least 60 days, an Insured is Certified as Terminally Ill. In order for this benefit to be paid:

(a) The Insured must make a Written Request; and

(b) Reliance Standard Life Insurance Company must receive from any assignee or irrevocable Beneficiary their signed acknowledgement and agreement to payment of this benefit.

Reliance Standard Life Insurance Company may, at its option, confirm the terminal diagnosis with a second medical exam performed at Reliance Standard Life Insurance Company's expense. If the second medical exam produces a conflicting diagnosis, Reliance Standard Life Insurance Company would arrange for a third medical exam to be performed at its expense. The initial terminal diagnosis would then be honored only if it is confirmed by the third opinion.

Amount of the Accelerated Benefit

The Accelerated Benefit will be an amount equal to 75% of the Death Benefit applicable to the Insured under the Certificate on the date of the Certification of Terminal Illness, subject to a maximum benefit of $500,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed by Reliance Standard Life Insurance Company and the Insured. The Accelerated Benefit is payable one time only for any Insured under this Rider.

Effect of Benefit

If an Insured becomes eligible for, and elects to receive this Accelerated Benefit, it will have the following effects:

(a) The Death Benefit payable for such Insured will be reduced by an amount equal to the Accelerated Benefit paid to such Insured. The amount of the Accelerated Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death Benefit in the absence of this Rider.

(b) Any amount of insurance that would otherwise be continued under a Waiver of Premium provision will be reduced proportionately, as will the maximum Face Amount available under the Conversion Privilege.

Misstatement of Age or Sex

The Accelerated Benefit will be adjusted to reflect the amount of benefit that would have been purchased by the actual premium paid at the correct age and sex.

Termination of an Individual's Coverage under the Accelerated Benefit Rider

The coverage of any Insured under this Rider will terminate on the first of the following:

(a) The date his/her coverage under the Policy terminates;

(b) The date of payment of the Accelerated Benefit for his/her Terminal Illness; or

(c) The date he/she attains age 75.

Additional Provisions

This Rider takes effect on the Effective Date shown. It will terminate on the date the Group Policy terminates. It is subject to all terms of the Group Policy not inconsistent herewith.

How Much Is Paid?

Please see the Schedule provided by your Employer.

All covered Employees are eligible for the death benefit. Death Benefits automatically reduce by the following percentages on the participant's 65th, 70th and 75th birthday. This benefit terminates at retirement. Percentages are based upon the principal amount in effect the day prior to the participant's 65th, 70th or 75th birthday whichever is applicable:

Reduction Percentage of Principal Amount	Effective
35%	65th Birthday
60%	70th Birthday
80%	75th Birthday

ACCIDENTAL DEATH AND DISMEMBERMENT

This benefit is fully insured through Reliance Standard Life Insurance Company (RSL).

Payment for dismemberment will be made to you. Payment for loss of life by accidental death will be made to your Beneficiary. If more than one loss occurred as a result of accidental means, payment shall be made for only the one loss for which the largest amount is payable. The loss must occur within three hundred sixty five (365) days after the date of the accident. This benefit is provided to the Employee only. No family members are eligible for this benefit.

Accidental Death

An accidental death benefit is paid to beneficiaries of Employees who have completed the eligibility requirements. In the case of accidental death your AD&D principal sum is equal to the amount of your group term Life Insurance benefit, including any applicable reduction as set out above, on the day of loss.

Accidental Dismemberment

Member(s) means: hand, foot or eye.

Loss(es) must result directly and independently from injury, with no other contributing cause. Loss of a hand or foot means complete severance through or above the wrist or ankle joints. Loss of an eye means the total and irrecoverable loss of sight. Loss of speech means total and irrecoverable loss of function. Loss of Hearing means total and irrecoverable loss of hearing in both ears. Loss of a thumb and index finger means the complete severance through or above the metacarpophalangeal joint.

In the case of the following you are entitled to the principal sum as above: loss of life, loss of two or more members, loss of sight of both eyes, loss of speech and hearing.

In the case of the following you are entitled to one-half of the principal amount: loss of one member, loss of speech or hearing.

In the case of the following you are entitled to one-quarter of the principal amount: loss of thumb and index finger of the same hand.

Losses Not Covered by Life or AD&D Benefit

In addition to the Plan Exclusions at the end of this booklet, this benefit does not cover losses in connection with any of the following:

Life Insurance:

Any loss while on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared)

Accidental Death and Dismemberment:

- An intentionally self inflicted injury;
- Any act of war, declared or undeclared;
- Sickness or disease which contributes to the loss (except infection which results from an accidental cut or wound).

YOUR BENEFICIARY

How to Name or Change a Beneficiary

To name a Beneficiary, simply complete the Beneficiary section of the enrollment form.

You may change your Beneficiary whenever you wish. To do so, merely complete a new form and make sure that it is sent in to the Benefit Manager at Chimes/DC. The change will take effect on the date you sign the new Beneficiary form. However, such change will not be in effect with regard to any payment made by the Plan until FCE receives the new Beneficiary form as submitted through Chimes/DC.

You Can Name More Than One Beneficiary

If you do so, you may also specify the share each is to receive of any benefits payable upon your death. If you do not specify, each Beneficiary will receive an equal share. If any of your beneficiaries are no longer alive upon your death, that person's share is divided equally among the surviving beneficiaries.

If You Do Not Name a Beneficiary

If you die without properly naming a Beneficiary, any benefits due as a result of your death will be paid in one sum in the following manner:

- 100% to any surviving spouse.
- If there is no surviving spouse, the benefits will be divided equally by any surviving children.
- If there is no surviving spouse or children, the benefits will be divided equally among the surviving parents.
- If there is no surviving spouse, children or parents, benefits will be divided equally among surviving brothers and sisters.
- If there are no surviving spouse, children, parents or brothers and sisters, the benefits will be paid to the executor or administrator of your estate.
- If your Beneficiary is a minor or incompetent, any benefits due as a result of your death shall be paid to the legally appointed guardian of your Beneficiary.

DEPENDENT'S LIFE INSURANCE BENEFITS

When an Insured Dependent dies, we will pay the applicable benefit shown in the Schedule. If the Insured is deceased, then the benefits will be paid to the Insured's Beneficiary. Your eligibility for the Dependent's death benefits stops when your coverage terminates or if you die. No Dependent Death Benefit will be paid in the event the decedent and the Dependent were husband and wife and were both Employees at the time of the death of the decedent. A person may not have coverage both as an Insured and as a covered Dependent. Only one eligible spouse may cover the eligible children as Insured Dependents.

A conversion privilege is available when your Dependent's life insurance is no longer in force. For details concerning this option, please refer to the subsection titled "Conversion Privilege" under the Life Insurance Benefits section of this booklet.

HEARING AID BENEFIT

This is an Employee benefit that must be medically necessary and is not available to Dependents.

Waiting Period

The appropriate Waiting Period for the Hearing Aid Benefit is six (6) months following the date of the participant's effective coverage in the Plan.

The Amount of the Benefit

The Schedule lists the maximum amount paid by the Plan and the Copayment required by the Employee. The benefit is available every three (3) calendar years and is based on the number of hours worked. Please refer to the Schedule.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

This Plan has an Employee Assistance Program for Employees and their eligible Dependents. Services include: Telephone crisis intervention, up to 4 sessions of in-person counseling, consultation, and referrals to appropriate resources for a variety of issues, including, but not limited to:

- Marital and family problems
- Emotional concerns, e.g., anxiety, depression and stress
- Substance abuse
- Job performance issues
- Financial concerns and referral/resources
- Dependent care issues

Legal Consultation Services: The initial in-person or telephone consultation is free. Subsequent visits or services are available at discounted rates depending on the type of issue. When you call, an attorney will explain your rights under the law and discuss your options for dealing with the problem. Examples of legal problems include:

- Housing and real estate matters
- Estate planning
- Family law, such as divorce, child custody and child support
- Car accidents and related matters
- Financial concerns

- Criminal and government matters

Excluded from this legal consultation service are consultations concerning the following:

- A lawsuit against your Employer
- Your personal business or commercial enterprise
- Medical/surgical second opinions
- Third-party advice

To Access: Call 1-800-424-4178. All calls are answered by professional, licensed clinicians 24 hours a day.

Please see the brochure included in your enrollment packet for a detailed description of this benefit.

FLU/HEPATITIS B VACCINES

Flu and Hepatitis B vaccines administered by Provider shall be an additional benefit covered at 100% for all Chimes/DC Employees. This benefit does not cover Dependents.

DISMISSAL WAGE / UNEMPLOYMENT BENEFIT (DUB)

This section of your Summary Plan Description (SPD) booklet applies to Employees who participate in the Dismissal Unemployment Benefit (DUB). In order to determine whether you are a DUB participant, please refer to the Schedule of Benefits provided by your Employer. If the applicable Schedule of Benefits includes a DUB as part of the Plan, then you are a DUB participant, in which case this SPD section applies to you. Otherwise, this SPD section does not apply.

The purpose of the Dismissal Wage/Unemployment Benefit (DUB) is to provide a loss of income benefit to a participant who suffers an unforeseen dismissal from employment and/or who actually experiences a period of unemployment, provided certain requirements are met.

Funding of the DUB

Employer contributions received by the Plan shall be allocated to the participants' accounts in the Plan. Contributions may vary as a result of work schedule variations, and allocations to employee's accounts may be calculated on an individual or group basis. Each employee shall have a separate DUB account. The contributions shall be contributed to the Plan's Trust and shall be invested into an interest-bearing account or certificate of deposit maintained by any federal or State chartered bank or savings and loan association.

Requirements for Receiving the DUB Benefit

In order to qualify to receive this DUB benefit, you must suffer a termination of employment as a result of contract termination or reduction in the work force ("layoff"), involuntary termination (with or without cause), or employee voluntary termination of employment ("quitting") with a period of unemployment of at least twenty-four hours following termination of employment. If you return to work for the same Employer within 30 days of termination, you will not qualify to receive a distribution, and your DUB account will continue to be administered as though there was no break in service. Further, termination of employment must be for reasons other than willful misconduct.

Your Employer will notify the Third Party Administrator (FCE Benefit Administrators, Inc.) of

your termination of employment in its weekly employee status report to the Third Party Administrator. Upon notification of your termination of employment, the Third Party Administrator will send to you a Benefit Request form. If you fail to return a completed Benefit Request form to the Third Party Administrator within 30 days from the date the Benefit Request form has been mailed to you, a second Benefit Request form will be mailed. If you fail to return the completed second Benefit Request form to the Third Party Administrator within 60 days from the date the second Benefit Request form has been mailed to you, the Dismissal Wage/Unemployment Benefit will be forfeited. Such forfeitures are reallocated to all remaining participants in the Plan, on a per capita basis.

After the Third Party Administrator receives the necessary paperwork and all Employer contributions for you, you can expect to receive a lump sum distribution of the DUB benefit within 60 days. (Note: it is not 60 days from termination of employment, but 60 days from the date the Third Party Administrator has everything it needs to process your claim, which may take a total of 90 to 120 days from termination.)

Although the Plan usually pays benefits in a lump sum, if you meet the eligibility requirements for unemployment benefits in your State (as determined by the Third Party Administrator), then the Plan benefit may (depending on the circumstances surrounding your termination of employment) be treated as a Supplemental Unemployment Benefit and will be paid to you in installments rather than in a lump sum.

Amount of Benefit

A number of factors affect the amount of your benefit upon termination of employment. Factors affecting the amount of benefit include the amount of monthly contributions to your account and your length of employment. The amount of the DUB benefit is the cash balance of your DUB account increased by earnings and forfeitures, and decreased by administrative expenses. Because the actual value of the DUB benefit is based on the above factors, the precise amount of benefit available at distribution can only be accurately determined at that time. In any event, the benefit cannot exceed twice the annual compensation you received in the year preceding termination.

Forfeiture of the Benefit

There is no guarantee that you will achieve eligibility for a DUB benefit distribution. The DUB benefit is forfeited under the following circumstances:

1) Dismissal from employment for willful misconduct. *
2) Voluntary termination of employment with no period of unemployment.
3) Death

* willful misconduct is an act or omission involving dishonesty or dereliction of duty, a transgression of an established and definite rule or criminal conduct (as determined by the Third Party Administrator). The act or omission may be active or passive, and must be willful in character and beyond simple negligence. Examples of willful misconduct include but are not limited to; walking off the job without proper notice or permission, failing to report to work without proper notice, disregarding or challenging instructions from a supervisor or company policy, etc..

Benefits are also forfeited if the Third Party Administrator does not hear from you within 60 days of the mailing date of the second Benefit Request form letter, as stated in the section above titled "Requirements for Receiving the DUB Benefit". Forfeitures are reallocated to all participants in the Plan, on a per capita basis.

Tax Consequences of the DUB Benefit

The DUB benefit is not taxable while you are employed. Contributions made on your behalf by your Employer while you are employed are free of income and payroll taxes. The DUB benefit becomes taxable to you upon your receipt of the DUB benefit.

If the benefit is paid out as Dismissal Wage, the Third Party Administrator must withhold from your gross DUB benefit amount Employee income and payroll taxes (i.e., FICA, Medicare, FUTA), before disbursing the net proceeds to you. If the benefit is paid out as a Supplemental Unemployment Benefit (SUB), the net disbursement will be free of all Federal payroll related taxes, however, the disbursement may be subject to Federal, State and local income tax withholding. You will receive a W-2 form to include with your annual tax filing. The circumstances surrounding your separation from the company at the time you terminate employment and your eligibility to receive unemployment benefits from your State will determine whether you receive the DUB benefit as a Dismissal Wage/Unemployment Benefit or a Supplemental Unemployment Benefit. The Benefit Request form that you will receive upon the Third Party Administrator's notification of your termination will allow you to indicate which benefit you are eligible for.

DUB Claim Considerations

Details concerning the claims procedure for non-health claims (such as a DUB benefit claim) is located in the section of this SPD titled "Claims Procedures."

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Special Rights upon Childbirth. Group health plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with children for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMAN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Plan covers medical and surgical benefits for mastectomies. Effective January 1, 1999, this coverage includes:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, or
- Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

CLAIM PROCEDURES

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office Benefit Manager or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician or Dentist complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

FCE Benefit Administrators, Inc.
445 Recoleta, Suite 100
San Antonio, TX 78216-7520
1-800-899-9355

Claims should be filed with the Claims Administrator within 120 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined unless it was not reasonably possible to submit the claim in that time. In any event, the claim must be submitted no later than one (1) year from the date incurred. All claims received later than one (1) year will be declined.

Please note that the following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures Regulations and should be interpreted accordingly. In the event of any conflict between this summary and those Regulations, the Regulations shall control. In addition, any changes in those Regulations will apply to the Plan automatically effective as of the date of those changes.

To receive Plan benefits, the claimant must follow the procedures established by the Claim

Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to the claimant.

The Plan reserves the right to have a Plan Participant seek a second opinion.

Initial Claims

Initial claims for Plan benefits are made to the Claim Administrator (FCE). The Claim Administrator will review the claim itself or appoint an individual or an entity to review the claim, following these procedures:

(a) Non-Health Benefit Claims. In the case of a claim that is not a health claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the reviewer before the end of the 90 day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond the day which is 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the Claimant's claim is for urgent care health benefits, the reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the reviewer will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could be adequately managed with the care or treatment which is the subject of the claim.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment of termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the

reviewer will notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. In the case of a health benefit claim not described above:

a. In the case of a pre-service health benefit claim, the reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. If, due to special circumstances, the reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the reviewer expects to make its decision. Under no circumstances may the reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

b. In the case of a post-service health benefit claim, the reviewer will notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the reviewer expects to make its decision. Under no circumstances may the reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days

from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment of services which the Claimant has already received.

(c) Manner and Content of Denial of Initial Claims. If the reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

(i) A description of the specific reasons for the denial;

(ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;

(iii) A description of any additional information that the Claimant must provide in order to perfect the claim (including an explanation of why the information is needed);

(iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial; and

(v) A statement of the Claimant's right to bring a civil action under a Federal law called "ERISA" following any denial on review of the initial denial.

In addition, in the case of a denial of health benefits, the following will be provided to the Claimant:

(i) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that a copy will be provided without charge upon request); and

(ii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, and explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that an explanation will be provided without charge upon request).

(In the case of an adverse benefit determination concerning a health claim involving urgent care, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with the Section is furnished not later than 3 days after the oral notification.)

Reviews of Initially Denied Claims

If a claim is submitted for Plan benefits and it is initially denied under the procedures described above, the claimant may request a review of that denial under the following procedures.

(a) Non-Health Benefit Claims. In the case of benefits other than health benefits, a request for review of a denied claim must be made in writing to the Claim Administrator within 60 days after receiving notice of the initial denial of the claim. The decision on review will be made within 60 days after the Claim Administrator's receipt of a request for review,

unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than one hundred twenty (120) days after receipt of a request for review.

The reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Claim Administrator. The reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health Benefit Claims. A Claimant whose initial claim for health benefits is denied may request a review of that denial by submitting the request in writing to the Claim Administrator no later than 180 days after the Claimant receives the notice of an adverse benefit determination. In addition to providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary of appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(iv) In the case of a requested review of a denied initial claim involving urgent health care, the review process shall meet the expedited deadlines described below. The Claimant's request for such an expedited review may be submitted orally or in writing by the Claimant and all necessary information, including the Plan's determination on review, shall be

transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. In case of urgent care health claims, the reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of the initial adverse determination by the Plan.

(ii) Other Health Benefit Claims.

a. In the case of a pre-service health claim, the reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of the Claimant's request for review of the initial adverse determination.

b. In the case of a post-service health claim, the reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after receipt by the Plan of the Claimant's request for review of the initial adverse determination.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial determination, the reviewer will provide the Claimant a written or electronic notice that includes:

(i) a description of its decision;

(ii) a description of the specific reasons for the decision;

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claimant's claim for benefits;

(v) a statement describing the Claimant's right to bring an action for judicial review under ERISA &502(a);

(vi) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(vii) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the

Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary, the period for making the determination will be "frozen" from the date the notification requesting the additional information is sent to the Claimant until the day the Claimant responds.

Plan's Failure to Follow Procedures

If the Plan fails to follow the claims procedures described above, a Claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Insured Benefits and State Law

With respect to any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supercede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action my be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Claim Administrator has been rendered (or deemed rendered).

COORDINATION OF BENEFITS

Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Benefit Plan

This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge

For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile Limitations

When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be

considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit Plan Payment Order

When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims Determination Period

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

Right of Subrogation and Refund

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or Insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount Subject to Subrogation or Refund

The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

The Plan will not be subject to any "make whole" or other subrogation rule.

Conditions Precedent to Coverage

The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined Terms

"Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery From Another Plan Under Which the Covered Person is Covered

This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator

The Plan Administrator has a right to request reports on and approve of all settlements.

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

Note: Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These employees must have made petitions for certification to apply for TAA on or after November 4, 2002.

The employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended.

Any employee who qualifies or may qualify for assistance under this special provision should contact his or her Plan Administrator for further information.

What is COBRA Continuation Coverage?

COBRA continuation coverage is group health plan coverage that an Employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non COBRA beneficiaries).

Who is a Qualified Beneficiary?

In general, a Qualified Beneficiary is:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

II. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

III. A covered Employee who retired on or before the date substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a Beneficiary under the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a non resident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

I. The death of a covered Employee

II. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

III. The divorce or legal separation of a covered Employee from the Employee's Spouse.

IV. A covered Employee's enrollment in the Medicare program.

V. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

VI. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in Contribution that must be paid by a covered Employee or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of

FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the Election Period and How Long Must it Last?

An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his/her right to elect COBRA continuation coverage.

Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of Their Occurrence of a Qualifying Event?

In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.
- The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of; the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of a loss of coverage resulting from a Qualifying Event and ending not before the earliest of the following dates:

I. The last day of the applicable maximum coverage period.

II. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

III. The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

IV. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

V. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

VI. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

a. (I) 29 months after the date of the loss of coverage as the result of a Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

b. The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a qualified Beneficiary.

What are the Maximum Coverage Periods for COBRA Continuation Coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

I. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the loss of coverage resulting from the Qualifying Event if there is not a disability extension or 29 months after the loss of coverage if there is a disability extension.

II. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

a. 36 months after the date the covered Employee enrolled in the Medicare program; or

b. 18 months (or 29 months, if there is a disability extension) after the loss of coverage resulting from the covered Employee's termination or reduction of hours of employment.

III. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the

retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after loss of coverage resulting from the death of the retired covered Employee.

- In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the loss of coverage resulting from the Qualifying Event.

der What Circumstances Can the Maximum Coverage Period be Expanded?

Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is owed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a month maximum coverage period, the original period is expanded to 36 months, but only individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no umstance can the COBRA maximum coverage period be expanded to more than 36 nths after the date of the Qualifying Event.

w Does a Qualified Beneficiary Become Entitled to a Disability Extension?

lisability extension will be granted if an individual (whether or not the covered Employee) o is a Qualified Beneficiary in connection with the Qualifying Event that is termination or uction of hours of a covered Employee's employment, is determined under Title II or XVI the Social Security Act to have been disabled at any time during the first 60 days of BRA continuation coverage. To qualify for the disability extension, the Qualified neficiary must also provide the Plan Administrator with notice of the disability ermination on a date that is both within 60 days after the date of the determination and ore the end of the original 18-month maximum coverage.

n a Plan Require Payment for COBRA Continuation Coverage?

s. For any period of COBRA continuation coverage, a Plan can require the payment of an ount that does not exceed 102% of the applicable premium except the Plan may require payment of an amount that does not exceed 150% of the applicable premium for any iod of COBRA continuation coverage covering a disabled Qualified Beneficiary that would be required to be made available in the absence of a disability extension. A group health n can terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day any period for which timely payment is not made to the Plan with respect to that Qualified neficiary.

ist the Plan Allow Payment for COBRA Continuation Coverage to be Made in nthly Installments?

The Plan is also permitted to allow for payment at other intervals.

iat is the Timely Payment for Payment for COBRA Continuation Coverage?

Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a Qualified Beneficiary be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

QUESTIONS REGARDING COBRA - If you have any questions regarding notification of your COBRA rights, please feel free to contact FCE at:

FCE Benefit Administrators, Inc.
COBRA Administration
445 Recoleta, Suite 100
San Antonio, TX 78216-7520
210-349-9801 or 800-899-WELL
TTY Phone Number for
Hearing Impaired
1-877-319-7145

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

ıPONSIBILITIES FOR PLAN ADMINISTRATION

ı Administrator

nes/DC, Inc. Health and Welfare Plan is the benefit plan of Chimes/DC, the Plan ıinistrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator ccordance with the provisions of ERISA. An individual may be appointed by Chimes/DC ɔe Plan Administrator and serve at the convenience of the Employer. If the Plan ıinistrator resigns, dies or is otherwise removed from the position, Chimes/DC shall oint a new Plan Administrator as soon as reasonably possible.

Plan Administrator shall administer this Plan in accordance with its terms and establish ɔolicies, interpretations, practices, and procedures. It is the express intent of this Plan that Plan Administrator shall have maximum legal discretionary authority to construe and rpret the terms and provisions of the Plan, to make determinations regarding issues which te to eligibility for benefits, to decide disputes which may arise relative to a Plan ticipant's rights, and to decide questions of Plan interpretation and those of fact relating to Plan. The decisions of the Plan Administrator will be final and binding on all interested ies.

vice of legal process may be made upon the Plan Administrator.

ies of the Plan Administrator

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

ın Administrator Compensation

ɜ Plan Administrator serves **without** compensation; however, all expenses for plan ninistration, including compensation for hired services, will be paid by the Plan.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Claims Administrator is Not a Fiduciary

A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Funding the Plan and Payment of Benefits

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived solely from the funds of the Employer.

Benefits are paid directly from the Plan through the Claims Administrator.

The Plan is not to be construed as a contract for or of employment.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Amending and Terminating the Plan

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Plan Participant in this FCE Administered Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrators office and at other specified locations (such as worksites) all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or Dependents may have to pay for such coverage.
- Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or Dependent has Creditable Coverage from another plan. The Employee or Dependent should be provided a Certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

ıder ERISA, there are steps a Plan Participant can take to enforce the above rights. For ıtance, if a Plan Participant requests a copy of Plan documents or the latest annual report ım the Plan and does not receive them within 30 days, he/she may file suit in a federal urt. In such a case, the court may require the Plan Administrator to provide the materials d to pay the Plan Participant up to $110 a day until he/she receives the materials, unless e materials were not sent because of reasons beyond the control of the Plan Administrator. he Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, e participant may file suit in a state or federal court.

addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning e qualified status of a domestic relations order or medical child support order, he/she may e suit in federal court.

addition to creating rights for Plan Participants, ERISA imposes obligations upon the ividuals who are responsible for the operation of the Plan. The individuals who operate the an, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the an Participants and their beneficiaries. No one, including the Employer or any other person, ay fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to event the Plan Participant from obtaining benefits under the Plan or from exercising his/her hts under ERISA.

it should happen that plan fiduciaries misuse the Plan's money, or if a Plan Participant is scriminated against for asserting his/her rights, he/she may seek assistance from the U.S. epartment of Labor, or may file a suit in a federal court. The court will decide who should ıy court costs and legal fees. If the Plan Participant is successful the court may order the ırson sued to pay these costs and fees. If the Plan Participant loses, the court may order n/her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

the Plan Participant has any questions about the Plan, he/she should contact the Plan dministrator. If the Plan Participant has any questions about this statement or his/her rights ıder ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan articipant should contact either the nearest area office of the Employee Benefits Security dministration, U.S. Department of Labor listed in the telephone directory or the Division of echnical Assistance and Inquiries, Employee Benefits Security Administration , at 200 onstitution Avenue, N.W., Washington, DC. 20210. You may also obtain certain ıblications about your rights and responsibilities under ERISA by calling the publications ıtline of the Employee Benefits Security Administration.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Person is an Employee or, under certain benefits other than Major Medical, a Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

lurable Medical Equipment means equipment which (a) can withstand repeated use, (b) is rimarily and customarily used to serve a medical purpose, (c) generally is not useful to a erson in the absence of an Illness or Injury and (d) is appropriate for use in the home.

:mployee means a person who is an Active, regular Employee of the Employer, regularly cheduled to work for the Employer in an Employee/Employer relationship.

:mployer is Chimes/DC.

:nrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of ne Waiting Period.

:RISA is the Employee Retirement Income Security Act of 1974, as amended.

:xperimental and/or Investigational means services, supplies, care and treatment which oes not constitute accepted medical practice properly within the range of appropriate nedical practice under the standards of the case and by the standards of a reasonably ubstantial, qualified, responsible, relevant segment of the medical and dental community or overnment oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the xperimental/nonexperimental standings of specific technologies. The Plan Administrator hall be guided by a reasonable interpretation of Plan provisions. The decisions shall be nade in good faith and rendered following a detailed factual background investigation of the laim and the proposed treatment. The decision of the Plan Administrator will be final and inding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Extended Care Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Fringe Benefit Obligation means the Employer's obligation under the Service Contract Act to contribute a mandated hourly amount to the Health & Welfare Plan on behalf of the Employee.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Extended Care Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

ll of these criteria must be met; merely because a Physician recommends or approves ertain care does not mean that it is Medically Necessary.

he Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of he Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is rganic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services r is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, ublished by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically ecommended weight by either 100 pounds or is twice the medically recommended weight for person of the same height, age and mobility as the Covered Person.

Network Provider is a Hospital, Physician or other health care provider that has entered into an agreement with the Plan to charge reduced fees to persons covered under the Plan.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Chimes/DC, Inc. Health and Welfare Plan, which is a benefits plan for certain employees of Chimes DC, Inc. and is described in this document.

Plan Participant is any Employee or, under certain benefits other than Major Medical, a Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Schedule means an outline of the Plan reimbursement formulas as well as payment limits on certain services. Chimes/DC furnishes this outline to eligible Employees as a document separate from this booklet.

Sickness for a covered Employee is Illness, disease or Pregnancy.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

ote: All exclusions related to Prescription Drugs are shown in the Prescription Drug lan.

ote: All exclusions related to Dental are shown in the Dental Plan.

or all Medical Benefits shown in the Schedule, a charge for the following is not overed:

(1) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(2) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(3) **Educational or vocational testing.** Services for educational or vocational testing or training.

(4) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(5) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(6) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(7) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult section of this Plan.

(8) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(9) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(10) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(11) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(12) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Extended Care Facility and paid by the Hospital or facility for the service.

(13) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(14) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.

(15) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.

(16) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(17) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(18) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(19) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(20) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(21) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity will be covered.

(22) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(23) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages

or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(24) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(25) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.

(26) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(27) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(28) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule.

(29) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(30) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

(31) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(32) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(33) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung illness such as emphysema or asthma.

(34) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(35) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.

(36) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

(37) **War.** Any loss that is due to a declared or undeclared act of war.

EXHIBIT 2H

Primary Care Plan

TABLE OF CONTENTS

INTRODUCTION

This document is a description of Chimes/DC, Inc. Health and Welfare Plan (the Plan). No oral interpretation can change this Plan. The Plan described is designed to protect Plan participants against certain health expenses.

Coverage under the Plan will take effect for an eligible Employee and eligible Dependents when the Employee and such Dependents satisfy the Waiting Period and all eligibility requirements of the Plan.

Chimes/DC fully intends to maintain this Plan indefinitely. However, Chimes/DC reserves the right to terminate, suspend, discontinue or amend the Plan at any time for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like.

Failure to meet the eligibility requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, lack of medical necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended or benefits are eliminated, the rights of covered Employees are limited to covered expenses incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and includes key sections:

The first five sections (**"Enrolling in the Plan", "When Benefits Become Effective", "Delay of Effective Coverage", "How to Qualify for Health and Welfare Benefits" and "When Eligibility for Benefits Terminates"**) explain eligibility under the Plan, funding of the Plan, when coverage takes effect and when coverage terminates.

"Network Instructions" provides information concerning the Plan's medical provider network, including provider selection guidance and network contact information.

"Covered Benefits" is the first of 24 consecutive sections (pages 8 to 31) that explain when a benefit applies and the types of charges covered.

"General Limitations and Exclusions" lists charges that are **not** covered.

"Coordination of Benefits" explains the Plan payment order when a person is covered under more than one plan.

"How to File a Claim for Benefits" and **"Claim Procedures"** explain the rules for claim filing and the claim appeal process.

"Subrogation" explains the Plan's right to recover payment of charges when a covered Employee has a claim against another person because of injuries sustained.

"COBRA Continuation of Medical Benefits" explains the continuation options which are provided by federal mandate when an Employee's coverage ceases under the Plan.

"Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)" explains the Plan's structure and the Employee's rights under the Plan.

"Glossary of Insurance Terms" defines those Plan terms that have a specific meaning.

ENROLLING IN THE PLAN

Submission of Employee Information

In order to process your claims completely and assure the highest level of benefits possible, eligible Employees should enroll for coverage by filling out and signing an enrollment form and sending it to the FCE office through your Employer.

Although FCE will issue ID cards and process most health & welfare claims for you solely on the basis of payroll information received from Chimes/DC, the properly completed enrollment form is the only source we have that informs us about your eligible Dependents and your chosen Beneficiary for the death benefit.

Funding

Participation in the Plan is mandatory for those Employees who meet the eligibility requirements and for whom the Employer pays contributions to the Plan. Chimes/DC pays the entire cost of Employee and Dependent coverage under this plan. Benefits are paid from the trust that has been established to receive contributions from the Chimes/DC and to pay benefits due under the Plan.

Important Notice Concerning the Submission of Dependent Information

While eligible Dependents of a covered Employee will technically be covered under this Plan on the later of the date of the Employee's eligibility or the date of the Dependent's eligibility, FCE's ability to describe benefits, authorize treatment and pay claims is contingent upon the receipt of a signed, updated enrollment form from the Employee containing complete information requested about the eligible Dependents.

Treatment will not be authorized and claims will not be paid for otherwise eligible Dependents who have not been included in or added to a signed enrollment form. Failure to add an otherwise eligible Dependent within six months of the date of service for an otherwise eligible treatment will cause that claim to be denied and returned to the provider as the Employee's responsibility.

Procedures Regarding Enrollment Forms

1. All enrollment forms should be signed and returned.
2. If a Contribution is made for the Employee, but no enrollment form is received, FCE will proceed as follows:
    a. Will verify benefits subject to eligibility.

b. Will pay all allowable Employee claims.

c. Will handle Dependent claims according to the procedure detailed in the subsection above titled "Important Notice Concerning the Submission of Dependent Information."

d. Will not deny a claim for eligibility reasons.

3. If a completed enrollment form includes an eligible Dependent or spouse with a different last name, a birth certificate listing the parents names must be submitted with the Dependent claim and a marriage certificate needs to be submitted with the spouse's claim.
4. Guardianship and full time student information will not be verified until a Claim is submitted.
5. If an unsigned enrollment form is received, it will be returned. If other information is required as well, all information will be requested at the same time as the signature.

It is very important to keep your enrollment form up-to-date. For example, if you move to a new address, if you marry or become divorced, if your Beneficiary dies, or if you have a new child, then your enrollment form should be updated. Report any important change at once to Chimes/DC Benefit Manager at 4815 Seton Drive, Baltimore, MD 21215 or fax the enrollment form to 410-358-0031.

Who Are Eligible Employees and Dependents?

An eligible Employee is an Employee who has completed the Waiting Period shown on the Schedule and on whose behalf the Employer has agreed to contribute to the plan.

Eligible dependents are limited to the following:

1. The legal spouse of an Employee, provided that a person shall not be considered the spouse of an Employee if that person is either divorced from the Employee, legally separated from the Employee or has not resided with the Employee for one year or more prior to the date any benefit specified in this booklet becomes due.
2. Unmarried children, whether natural or lawfully adopted, under 19 years of age who rely upon you for support, live with you in a normal parent-child relationship and who are not employed on a full-time basis, unless otherwise required by any Qualified Medical Child Support Order. Stepchildren and grandchildren must be lawfully adopted by you in order to qualify as eligible Dependents. Children are not eligible for coverage the first 10 days of life. Newborn routine nursery care is not covered under this Plan.
3. Your unmarried children at age 19, if they are full-time students at an accredited school or college and depend solely on you for support, until they reach age 25 years. Proof of student status must be received by FCE before an otherwise allowable claim can be paid. Eligibility for coverage will be verified to a health provider subject to receiving proof of student status and the claim will be processed. Upon receipt of the proof of full-time student status FCE will pay the claim. (A full-time student is a student enrolled in an accredited institution with 12 or more credits.)

Any Employee's child, regardless of age, who is incapable of self-support because of physical handicap or mental retardation and who is dependent upon the Employee for support will continue to be eligible for dependent benefits provided that the incapacity began before he or she reached the age of 19 years or before the age of 25 years if he

or she attended an accredited college or university as set forth above. Proof of such a child's incapacity must be furnished to the Trustee no later than 31 days after the child reaches the age limit in question. The Trustee may require proof of the continued existence of such incapacity from time to time.

Common Law Spousal Eligibility

Common law spouses are not recognized as eligible under the Plan unless the following conditions are met:

1) The Employee must prove the existence of a common law marriage by providing documentation to the Plan from the state in which the common law marriage agreement was initiated.
2) The Employee must provide documentation to the Plan satisfying at least four of the following requirements (a. through h.):
    a. Proof of shared residence for a minimum of three years. Three of the following must be presented to be considered proof of residence:
        i. Driver's license;
        ii. Residential utility bills;
        iii. Voter registration cards;
        iv. Lease containing both signatures;
        v. Mortgage listing both as mortgagees.
    b. Birth certificates listing both the Employee and common law spouse as parents of any minor children.
    c. Federal income tax return filed jointly.
    d. Proof of a shared surname.
    e. Life insurance policies listing one common law spouse as a beneficiary of the other.
    f. Policy from another insurance plan listing the one common law spouse as a covered dependent of the other.
    g. Proof of joint ownership of property (e.g., vehicle, house, etc.).
    h. Proof of joint checking and/or savings accounts.

Qualified Support Orders

The Plan recognizes Dependent child coverage as required under a Qualified Medical Child Support Order, a National Medical Support Notice or other appropriate court order, as determined by the Plan Administrator. The Plan also recognizes coverage as required under a Qualified Domestic Relations Order with respect to a former spouse. The Plan has procedures in place to qualify such orders or notices. If you have an order or notice requiring coverage of a child or former spouse under the Plan, you should contact the Plan Administrator immediately to determine whether the order or notice is qualified. You and your beneficiaries may obtain, without charge, a copy of these procedures from the Plan Administrator.

WHEN BENEFITS BECOME EFFECTIVE

You must satisfy the Waiting Period and your Employer must make Contributions to the Plan for the Waiting Period (in accordance with your work schedule) in order for your benefit coverage under the Plan to become effective. Eligibility will be determined as follows:

Initial Coverage Group: Those Employees who were covered under the Employer's prior plan as of December 31, 2002. The effective date will be January 1, 2003.

Subsequently Covered Employees: Those Employees will be covered for benefits based on the Schedule following the date that the Employee first renders services on behalf of the Employer.

Dependents are eligible for coverage at the time the Employee enters the Plan, and should be enrolled in the Plan for the reasons stipulated on page 2 of this booklet under the subsection titled "Important Notice Concerning the Submission of Dependent Information."

DELAY OF EFFECTIVE COVERAGE

1. You must satisfy the Waiting Period and your Employer must make Contributions to the Plan for the Waiting Period (in accordance with your work schedule) in order for your benefit coverage under the Plan to become effective. Should you stop working for any reason during the Waiting Period, your Effective Date will be delayed until you return to work and satisfy the unmet balance of the Waiting Period. In the event you do not return to work within 12 weeks, a new Waiting Period must be satisfied upon your return.
2. If you are not actively at work on the day coverage becomes effective, but the Waiting Period and Contribution requirement have otherwise been met:
    a. If the reason for your absence is due to health-related factors, your Effective Date will not be delayed.
    b. If the reason for your absence is due to non-health-related factors, your Effective Date will be delayed until you return to active employment. Again, if you do not return to work within 12 weeks, a new Waiting Period must be satisfied upon your return.

HOW TO QUALIFY FOR HEALTH AND WELFARE BENEFITS

Health and welfare benefits are administered by FCE for active Employees who are eligible and also for their eligible Dependents. The amount of your benefits for certain coverage items is based on the number of hours you normally work per week for which Contributions are received. Your actual worked hours for claims processing purposes are determined by averaging the Employer reported hours received in house for the 13 week period prior to the month in which the claim was incurred.

The amount of benefits provided for active Employees and their eligible dependents is broken down into four classifications and depends on how many fringe hours your Employer notifies the plan that you work per week. The highest level of total benefits is available for active Employees and their eligible dependents that are in Class IV. As you go from Class IV to Class I, the amount of benefits available decreases. Please refer to the Schedule to determine which classification includes your benefits.

WHEN ELIGIBILITY FOR BENEFITS TERMINATES

You and your dependents' eligibility for benefits terminates when the Third Party Administrator stops receiving Contributions for your coverage. Contributions will cease if

you leave the employment of your Employer, if your Employer fails to timely pay the required Contributions, and/or if the Plan is terminated. An Employee so situated will receive extended coverage equal to one month after Contributions to the Plan cease.

If you terminate employment or your Employer terminates Contributions on your behalf, prior to reaching your effective date of coverage, you will not be covered under the plan and your Employer paid Contributions will not be refunded.

Contributions and eligibility will terminate for your unmarried children at age 19, unless they are full-time students at an accredited school or college and depend solely on you for support, until they reach age 25 years. (Refer to the section beginning on page 2 of this booklet titled "Enrolling in the Plan" for an explanation of Dependent student eligibility requirements.)

Coverage for your unmarried children who are mentally or physically handicapped and incapable of earning their own living, can be continued beyond age 19 if their disability began prior to age 19 and if you provide proof of disability within 31 days of their 19th birthday. You may be asked for additional proof from time to time.

You are required to turn in your insurance identification card to the Employer, or to FCE Benefit Administrators, at the time your coverage terminates. If you fail to do so and you use your insurance identification card after your coverage terminates, you will be responsible for all of the costs associated with such use. In addition, if you use your card after your coverage terminates, such action constitutes fraud, and you may be liable for both civil and criminal penalties for such unauthorized use. Either FCE Benefit Administrators or your Employer, or both, will seek legal redress of such unauthorized use of your insurance identification card, to the maximum extent permitted.

CONTINUATION OF COVERAGE AFTER LOSS OF ELIGIBILITY FOR BENEFITS

If an Employee or eligible Dependent loses eligibility for the medical benefits described in this booklet by reason of termination of employment, reduction in hours, death, divorce or separation, or by reason of an eligible Dependent child's loss of eligibility, such Employee or eligible Dependent, at their own expense, may elect to continue coverage for such benefits. The length of time such coverage may be continued depends on the reason for loss of eligibility and the physical condition of the Employee or eligible Dependent.

A detailed description of the rules and procedures governing COBRA Continuation of Coverage is set out on beginning on page 47 of this booklet.

CONTINUATION DURING FAMILY AND MEDICAL LEAVE ACT

Effective August 5, 1993, the Family and Medical Leave Act of 1993 (FMLA) was enacted to allow eligible Employees the right to take up to 12 weeks, or the maximum number of weeks and hours as specified by local jurisdiction regulation, of unpaid leave to care for themselves or a relative. If you elect to take this leave and later notify Chimes/DC that you will not be returning, you have the ability to continue your coverage for 18 months from the date benefits are terminated.

This Plan shall at all times comply with the Family and Medical Leave Act of 1993 (as promulgated in regulations issued by the Department of Labor) or with the regulations enforced in a local jurisdiction if such regulations are more expansive than FMLA.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his/her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when the coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his/her Dependents when Plan coverage terminated. The level of plan coverage during your disability is based on an average fringe paid hours for the 13 week period immediately preceding your family leave.

REHIRING A TERMINATED EMPLOYEE

A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment Waiting Period.

EMPLOYEES ON MILITARY LEAVE

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

1. The maximum period of coverage of a person under such an election shall be lesser of:
    a. The 18 month period beginning on the date on which the person's absence begins; or
    b. The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
2. A person who elects to continue health plan coverage may be required to pay up to 102% of the full Contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for coverage.

An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

NETWORK INSTRUCTIONS

In-Network Provider Selection - 1-800-342-3289

You and your eligible dependents have access to Alliance PPO, LLC/Mid Atlantic Psychiatric Services, Inc. (Alliance PPO) a Preferred Provider Network (PPO). Alliance PPO consists of credentialed medical health care professionals, while MAPSI is comprised of behavioral health care professionals. The Alliance PPO/MAPSI participating hospitals, facilities, doctors, and other health care providers have contracted to provide medical services and treatment at a reduced or contracted cost. The savings created by the network are passed along to you in the form of lower plan Copayments and out of pocket expenses. You may call Alliance PPO/MAPSI at 1-800-342-3289 for assistance in locating a participating provider, or to find out whether your medical provider is already in the Alliance PPO/MAPSI network. You may also refer a non-participating medical provider to Alliance PPO/MAPSI if he or she is interested in applying for participation, however, referral does not mean that the provider will automatically become a participating provider in the network. When you call Alliance PPO/MAPSI please identify yourself as an Employee of Chimes/DC.

The medical providers listed in the Directory are participating as of the date of publication of the Directory. However, a listed provider may not be participating in the Network at the time of your appointment. When making an appointment with the doctor, hospital or other medical provider that you have chosen, please remember to identify your Plan as Alliance PPO/MAPSI. In addition, current participating provider status should be verified by calling Alliance PPO/MAPSI at 1-800-342-3289 or checking the website at www.mamsi.com.

Out-of-Network Provider Selection

In the event that you use an out-of-network provider, your benefits will be reduced as indicated on the Schedule.

IF YOU LIVE IN AN AREA THAT DOES NOT HAVE APPROPRIATE PROVIDER ACCESS WITHIN 30 MILES OF YOUR PRINCIPAL PLACE OF RESIDENCE AND YOU NOTIFY FCE AT 1-800-899-9355, THEN THE CLAIM WILL BE ADJUDICATED AS THOUGH AN IN-NETWORK PROVIDER HAD PERFORMED THE SERVICES.

Out-of-Network While Traveling

If you travel out of your coverage area, call the Alliance network at 1-800-342-3289 to find out the location of network providers in the area you will be visiting. Failure to contact the network will cause out-of-network penalties to be applied. Co-payments and Coinsurance factors and maximum out-of-pocket will be treated as out-of-network.

COVERED BENEFITS

The benefits provided under the Plan include:

1. Death Benefits
2. Accidental Death and Dismemberment
3. Hospital Room & Board
4. Hospital Miscellaneous Expense
10. Dental Care
11. Vision Care
12. Supplemental Accident Benefit
13. Hearing Aid Benefit

5. Anesthesiologist Benefits
6. Surgical Benefits
7. Doctor Visits
8. Doctor Ordered Lab/X-Ray
9. Prescription Benefits
14. Maternity Benefits
15. Physician's Hospital Visit
16. Mental, Nervous, Alcohol and Drug Abuse
17. Flu/Hepatitis B Vaccines

Detailed descriptions of all benefits are contained in later pages of this booklet. You may use any licensed medical doctor, dentist, optometrist or hospital you choose. This plan does not restrict you to specific medical providers; however, the plan provides greater benefits if you use in-network providers rather than out-of-network providers.

HOSPITAL ROOM & BOARD BENEFIT

If you or your eligible dependent become hospital confined as a result of a sickness or injury, the Plan provides a daily benefit for each day of confinement not to exceed the scheduled number of days shown on the Schedule provided to you by your Employer for all hospital confinements due to an accident or during a period of illness.

Amount of Hospital Room & Board Benefit

The amount of the hospital room & board daily benefit is based on your classification and is shown on the Schedule.

Hospitalization Not Covered By This Benefit

In addition to the General Limitations and Exclusions to all Plan Benefits starting on page 31, the Plan does not pay for any period of hospitalization in connection with the following:

- Sickness or injury (a) which arises out of or in the course of any occupation or employment for wage or profit, or (b) for which the Employee or (eligible dependent) is entitled to benefits under any worker's compensation or occupational disease law.
- Sickness or injury resulting from war or any act of war, declared or undeclared.
- Sickness or injury caused or contributed to by self-infliction. This exclusion does not apply if the injury was caused by domestic violence or a medical (including both physical and mental) condition.

MISCELLANEOUS HOSPITAL EXPENSE BENEFIT

The Plan also pays for the actual charges made by a hospital, for necessary services and supplies other than room and board furnished to you or one of your eligible dependents by the hospital during a period of confinement. There is a limitation on the maximum daily amount that will be paid for a claim under this benefit. The maximum daily amount that will be paid by the Plan, based on your classification, is shown on the Schedule.

THINGS to REMEMBER REGARDING HOSPITAL ROOM & BOARD and HOSPITAL MISCELLANEOUS EXPENSE BENEFITS

To be entitled to these hospital benefits:

You or your eligible dependent must be confined in a hospital as defined in the definitions section of this booklet.

There must be a charge by the hospital for room and board and the admission must be, at minimum, an overnight stay inclusive of midnight.

The hospital confinement must begin while you are eligible for benefits. The number of days of confinement and the services on which the claim is based must be recommended and approved by a legally qualified physician.

In addition to the General Limitations and Exclusions to all Plan Benefits set forth starting on page 31, the following charges are not covered under the Hospital Room and Board and Miscellaneous Hospital Benefits:

- Charges for patient convenience items.
- Charges for any doctors' services.
- Charges for special or private duty nursing services.
- Charges for anesthesiologist's services, unless otherwise covered on the Schedule.
- Charges for an emergency room visit, unless that visit results in a hospital admission as an inpatient.
- Charges for ICU and Coronary Care, if the Schedule includes a specific provision for these expenses.

OUTPATIENT X-RAY AND LAB BENEFIT

If you or your eligible dependents receive a laboratory test or x-ray examination which is made or recommended by a legally qualified physician and the test or examination is made in connection with a non-job related accidental bodily injury or sickness, the Plan will cover charges for the amount of fees actually charged for such examination up to the scheduled annual maximum shown on the Schedule based on your classification.

Examinations Not Covered By This Benefit

Payment will not be made for any laboratory tests or x-ray examinations made in connection with eye examinations or the fitting of glasses, x-ray therapy, x-rays or laboratory tests made during confinement in a hospital, or x-rays made for diagnosis or treatment of disorders of the teeth or gums.

DOCTOR'S VISIT EXPENSE BENEFIT

The Plan will provide certain benefits if you or your eligible dependent incur certain charges on an outpatient basis as a result of any sickness or injury which does not arise out of or in the course of any employment for wage or profit. There is a deductible or co-payment amount, which must be paid by you before the Plan will pay for any of the

charges in excess of the deductible or co-payment amount. The Plan will pay 100% of such excess charges up to the maximum annual benefit allowed in excess of the scheduled deductible or co-payment.

What Charges Are Covered By This Benefit?

This benefit covers all charges (including emergency room charges) incurred by you or your eligible dependent as a result of any sickness or injury which does not arise out of or in the course of any employment for wage or profit, which:

a. Are necessary to the care and treatment of sickness or injury and are incurred on the recommendation of a legally qualified physician to include office administered injectable anti-inflammatory agents, and injectable allergy related medications.

b. Are not in excess of the reasonable charges, which would customarily be made for the same services and supplies under similar conditions in your community.

What Is the Amount of the Deductible or Co-payment?

The amount of the deductible or co-payment is shown on the Schedule.

What Is the Amount of the Benefit?

The maximum Doctor's Visit Benefit that will be paid per benefit year over the deductible or co-payment specified above is based on your classification and listed on the Schedule.

What Charges Are Not Included Under This Benefit?

In addition to the General Exclusions and Limitations to all Plan Benefits set forth on page 31 the following are excluded charges for which no benefits will be payable:

Any charge incurred by the employee or eligible dependent:

1. For surgical operations (refer to Outpatient Surgery for exception).
2. For treatment of mental disorders, including charges for visits or consultations, with a psychiatrist or psychoanalyst.
3. For eye refractions, or the purchase of hearing aids or eyeglasses or the fitting thereof.
4. For medical exams not necessary to the treatment of sickness or disease, unless otherwise indicated on the Schedule.
5. For charges for drugs and medicines administered in a Doctor's office or emergency room, except Doctor's office administered injectable antibiotics, injectable anti-inflammatory agents, and injectable allergy related medications.
6. For non-prescription drugs.
7. For prescription drugs purchased at a pharmacy.
8. Charges for telephone consultations.
9. Physician Hospital (Inpatient) visits.

PHYSICIAN'S HOSPITAL VISIT EXPENSE BENEFIT

The Physician's Hospital Visit Benefit pays for charges made by physicians for inpatient hospital visits while you are confined, and the Doctor's Visits Expense Benefit is charged for outpatient Doctor's Visits exclusively.

There is a limitation on the maximum daily amount that will be paid for a claim under this benefit. The maximum daily amount that will be paid by the Plan, based on your classification, is shown on the Schedule provided to you by your Employer.

VISITING THE EMERGENCY ROOM

Outpatient visits to the emergency room for a covered diagnosis are payable as follows:

- Charges for any x-ray or lab work that is done will be considered under the x-ray and lab benefit.
- Charges for the emergency room, doctor's services, medical procedures, or medical supplies will be considered under the Doctor's Visit Expense Benefit.
- If you are admitted to the hospital through the emergency room all emergency room charges are payable under the Miscellaneous Hospital Benefit.
- Charges for any surgically classified procedures done in the emergency room (e.g. stitches, setting bones, etc.) will be considered under the Surgical Benefit, according to the scheduled amount for that procedure.
- Any anesthetic used in the emergency room will be considered under the Anesthesiologist's Benefit.

Note: All of the above benefits will be substantially reduced by the amount paid for just visiting the emergency room. Emergency room visits are normally quite expensive and this is not an unlimited benefit plan. Therefore, it is suggested that for non-emergency situations, such as a headache or the symptoms of the common cold or the flu, you should visit your family physician, an urgent care facility or a minor emergency clinic in order to avoid prematurely "maxing out" your benefit amounts needlessly.

SURGICAL BENEFITS

The Plan provides a benefit for surgical operations performed on you or your eligible dependent. A Schedule of Surgical Benefits starting on page 61 of this booklet. Once again, this benefit is only available as a result of an accident or disease which is not related to your job and for which benefits are not payable under any Worker's Compensation law.

How Surgical Benefits Are Calculated

As before, the amount of your surgical benefit depends on your classification. In this case, however, the surgical benefit is the same regardless of whether you or your eligible dependent has the operation (unless otherwise scheduled). We will explain how you can figure out exactly what your benefit is for any operation by referring to your maximum surgical benefit and your "Percent of Allowable Charges Paid" on the Schedule.

Surgical Example

We will use the example of an operation identified as "Appendectomy", CPT (current procedural technology) code 44950. The amount of benefit allowed for such a surgical procedure starting on page 61 on the Schedule of Surgical Benefits contained in this booklet. As you can see, the amount listed for this surgical procedure is $1,314.17. To figure out the amount of the surgical benefit to which you are entitled if you or your eligible dependent has this operation, you simply multiply the $1,314.17 times the "Percent of Allowable Charges Paid" listed under your classification on the Schedule provided to you by your Employer. In no event will you be entitled to receive more than your maximum surgical benefit.

To determine the correct CPT code for the procedure, which your doctor has recommended, please check with the doctor's office. If a procedure is not listed in the Schedule of Surgical Benefits you may call the claims office with the correct CPT code to obtain the scheduled amount for the surgery.

When the Actual Charge for the Operation Is Less than the Amount of the Benefit Provided By the Plan

If the actual charges of the operating physician are less than the amount provided by the Plan, actual charges will be paid. Coinsurance and Co-payments are specifically stated on the Schedule provided to you by your Employer.

When Surgical Benefits Are Payable

Surgical benefits are payable whether the procedure is performed in a hospital or doctor's office, but the procedure must be performed by a legally qualified physician during a time when you are eligible for benefits. No benefits are payable for charges incurred for cosmetic plastic surgery unless brought about by injury or disease occurring while you are eligible for benefits.

When Two or More Surgical Procedures Are Performed During a Single Operation

When two or more surgical procedures are performed during the course of a single operation, payment will be made for each surgical procedure unless the Schedule of Surgical Benefits sets out a maximum amount for a particular combination of surgical procedures.

Maximum Benefit Payable For All Surgical Procedures Performed During Any One Continuous Period of Disability

The total amount payable for all surgical procedures performed during any one continuous period of disability will not exceed your maximum surgical benefit.

OUTPATIENT SURGERY

Charges for covered surgical procedures done on an outpatient basis will be paid for in the following manner:

Charges for the services of an Anesthesiologist will be paid under the Anesthesiologist Benefit.

Physician charges for the surgical procedure will be covered under the surgical benefit according to the Schedule of Surgical Benefits.

Charges for supplies used during the procedure will be paid under the Miscellaneous Hospital Benefit, but will be limited to the maximum daily benefit.

Any operating room or recovery room use charges will be paid first under the Hospital Room & Board Benefit, but will be limited to the maximum daily benefit. Should the facilities charges exceed the maximum daily Hospital Room & Board benefit; the balance will be paid under the Physician's Hospital Visit.

All benefits applicable to outpatient surgery are subject to the maximums allowed which vary according to the Employee's classification. Please see the Schedule outlined on the Schedule for determination of maximums allowed.

All exclusions listed for each of the above benefits will be applied when charges are considered for outpatient surgery.

ANESTHESIOLOGIST BENEFIT

A benefit is provided by the Plan in the event of a surgical procedure to pay the anesthesiologist's charges to the extent the Employee's classification allows. The specific amount allowed is shown on the Schedule. This benefit is for all charges made by an anesthesiologist for services, to include, but not limited to consultations or visits before or after the surgical procedure.

The payment for the anesthesiologist charges is in addition to any amount payable under the Surgical Schedule. However, if the amount of the actual charges is less than the amount provided by the Plan, the amount paid by the Plan will also include any charges for the anesthesia used during the Surgery. In no event will the amount paid by the Plan exceed the amount of the actual charges. The Plan will pay anesthesiologist charges only with a corresponding claim for surgery. This benefit is not payable for any charges incurred for the administration of anesthesia for dental procedures, unless the procedure is done in a hospital as an inpatient.

DENTAL BENEFIT

The Plan will provide benefits for certain dental procedures incurred by you or your eligible dependents. In connection with the payment of dental benefits there is a maximum calendar year amount that the Plan will pay, a calendar year Deductible you must pay and a Waiting Period on Major Restorations that must be satisfied before your Plan will pay benefits.

What is Covered

The Summary of Dental Benefits located on the Schedule shows the payment percentage and Deductible amount applicable to the various covered expenses. The amount of coverage for you and your dependents is determined by the hours you work.

If the Plan pays less than 100%, you must pay the remaining percentage of covered services.

Services must be necessary for the diagnosis, prevention or correction of dental disease, defect or injury. Services must be recommended or prescribed by a licensed Dentist or Doctor, or performed by a dental hygienist working under the supervision of a Dentist.

Expenses are covered only if incurred and completed while a Participant is covered for these dental benefits.

To be eligible for certain dental benefits (e.g., prosthetics, bridges, partials or complete dentures, and space maintainers, including adjustment and repair thereto), you must be covered by the Plan for twelve (12) consecutive months.

Preventive Care

Covered at 80% and subject to the Deductible

Participants may receive the following services twice each calendar year, but not more than once in any five-month period.

- Oral examinations.
- Cleaning of teeth.
- Bitewing x-rays.
- Topical application of fluoride solution for dependent children to age 14 and under.
- Sealants for children age 14 and under

Basic Care

Covered at 80% and subject to the Deductible

Basic care includes:

- Extractions and alveolectomy at the time of tooth extraction.
- Amalgam, silicate, acrylic, and composite fillings.
- Dental surgery.
- X-ray and lab procedures required for dental surgery.
- A full-mouth series of x-rays once in a 36 month period.
- General anesthesia required for dental surgery.
- Care for the relief of dental pain.
- Drugs that require a Dentist's written prescription, including medication given at the Dentist's office.
- For Participants age 14 and under, space maintainers for missing primary teeth and habit-breaking appliances.
- Consultations required by the attending Dentist.
- Relines and rebases to existing dentures.
- Endodontic and Periodontal Care.

Major Care

(12 Month Waiting Period) Covered at 50% and subject to the Deductible

Major care includes:

- Crowns, inlays and onlays.
- Fixed bridge restorations.
- Removable partial or complete dentures.
- Repairs to existing dentures.
- Initial placement of full or partial dentures or bridgework, including abatements, but only if they are needed to replace natural teeth pulled after coverage begins.
- Replacement of existing full or partial dentures, bridgework or crowns; or the addition of teeth, inlays, onlays, crowns, or gold restorations to these appliances only if:
  - The existing appliance cannot be repaired or restored to use;
  - The Participant has been covered at least twelve (12) months;
  - At least five (5) years have passed since the last placement; or

  The replacement:
  - Replaces an existing temporary appliance that was placed after the date on which the Participant became covered; and
  - Is placed within twelve (12) months after the temporary appliance was placed; or

  The replacement:
  - Is needed because of the pulling of additional natural teeth or accidental injury to natural teeth (except for chewing injuries) while covered; and
  - Is completed within twelve (12) months of the extraction or accidental injury.

If a Participant has a partial denture, and a natural tooth adjacent to that denture is pulled while the Participant is covered, the addition of another tooth to the Participant's denture is covered.

Exclusions From Covered Dental Expenses

In addition to the General Limitations and Exclusions to all Plan Benefits starting on page 31:

Covered dental expense benefits under the Plan do not include and no benefits will be payable for or on account of any of the following:

- Charges incurred in connection with the treatment of a congenital malformation except that this exclusion shall not apply to such charges when they are incurred following a period of thirty six (36) consecutive months during which the person has been continuously eligible for benefits under the Plan.
- Charges incurred for services or supplies that are unreasonably priced or not reasonably necessary in the light of the dental procedure being treated; for purposes of determining whether a particular charge comes within this exclusion and for the purposes of determining what part, if any, of a particular charge that does come within this exclusion, it is, nevertheless, to be allowed as a covered

dental expense because such part represents neither an overcharge nor a luxury, the Plan will take into consideration the fees and prices generally charged and the services and supplies generally furnished in the area concerned for cases comparable to the case being treated, and in no event shall payment for fees and charges equivalent to those made by the National Dental Advisory Service Comprehensive Fee Report at the 80th percentile commonly referred to as NDAS in the area concerned be considered unreasonable; it being the intent of this exclusion that the benefits hereunder shall not cover charges for services or supplies that a reasonable person would consider to be priced unreasonably high or to be of a luxury nature

- Charges incurred in connection with any treatment to the teeth or gums for tumors.
- Charges for cosmetic reasons, including charges to personalize dentures.
- Charges for treatment of Temporomandibular Joint syndrome (TMJ).
- Charges incurred in connection with orthodontic services.
- Charges for sealants for covered persons older than 14 years of age at the time of service.
- Charges incurred by a covered Participant who has lost one or more teeth before becoming insured under this Plan. The Plan does not pay for dentures or bridgework that replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered Participant became insured under the Plan.
- Charges payable under Worker's Compensation.

VISION CARE BENEFIT

Coverage is provided for you or your eligible dependent for an eye examination, the purchase of single vision or bifocal vision lenses, and frames. The maximum amount paid for each vision benefit is listed on the Schedule.

Restriction on Payment of Vision Benefits

Vision care benefits shall not be payable unless otherwise stated on the Schedule for:

- More than one complete examination per person per calendar year.
- Not more than two lenses per person every two calendar years.
- Not more than one set of frames per person every two calendar years.
- Any loss or expense caused, incurred for, or resulting from:
  - Procedures or supplies furnished on account of visual defect which arises out of or in the course of your or your dependent's job;
  - Any medical or surgical treatment of the eye;
  - Sunglasses plain or prescription, or safety lenses or goggles;
  - Othoptics, vision training or aniseikonia.
- Charges payable under Worker's Compensation.

CONTINUATION OF BENEFITS DURING AN AUTHORIZED LEAVE (CBDAL)

The Plan will continue to cover you and your eligible dependents with health care benefits while you are prevented from working due to your serious health condition, the serious health condition of your spouse, child or parent. The CBDAL Benefit is also provided to care for your child after birth, or placement for adoption or foster care, provided that the disabling medical or family event occurs on or after the effective date of coverage. If the disability results from your serious health condition, you must be under the care of a legally qualified Physician and your disability must result from non-job related accident, sickness or disease for which benefits are not payable under any workmen's compensation law. If the authorized leave results from the need to care for your seriously ill spouse, child or parent, medical certification will be required.

Eligibility for Benefits

You are eligible for this benefit if you have worked for the Chimes/DC for at least one year and for 1,250 hours or the minimum number of hours as specified by your local jurisdiction regulations over the 12 months previous to the authorized leave. Any Employee who is denied job-protected family medical leave is not eligible for this benefit.

Level of Coverage

The level of plan coverage during your disability is based on average fringe paid hours for the 13 week period immediately preceding your authorized leave.

Maximum Number of Weeks

The CBDAL Benefit has a Plan year maximum of 12 weeks, or the maximum number of weeks as specified by local jurisdiction regulations, of coverage per calendar year.

SUPPLEMENTAL ACCIDENT BENEFIT

If you suffer an accidental bodily injury, which is not covered, by any Worker's Compensation Law or State Disability Insurance you are entitled to a Supplemental Accident Benefit in co-ordination with the amounts provided by other Plan benefits.

Amounts of the Supplemental Accident Expense Benefit

Under this benefit you are entitled to be reimbursed up to a maximum amount per accident, for eligible medical and dental expenses actually incurred less the usual benefits paid under this plan. This means that this benefit covers any coinsurance that would be otherwise payable and extends any otherwise exhausted plan maximum to the extent of the remaining Supplemental Accident Benefit. Expenses defined as payable under the medical and dental plans are payable under this benefit.

The maximum Benefit per Accident is based on your classification and is shown on the Schedule. No Supplemental Accident Benefit will be paid for accidents occurring prior to the effective date of coverage under this plan.

LIFE INSURANCE BENEFITS

This benefit is fully insured through Reliance Standard Life Insurance Company (RSL).

Life Insurance Benefits are payable in the event of your death from covered causes:

. While you are eligible for benefits.
. Upon submission of an original Death Certificate.
. Upon submission of a Police Report if one was prepared.

Conversion Privilege

You can use this privilege when your insurance is no longer in force. It has several parts. They are:

A. If the insurance ceases due to termination of employment or membership in any of the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within 90 days after you terminate. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:

- The policy will, at your option, be on any one of Reliance Standard Life's forms, except for term life insurance. It will be the standard type issued by Reliance Standard Life Insurance Company for the age and amount applied for;
- The policy issued will be for an amount not over what you had before you terminated;
- The premium due for the policy will be at Reliance Standard Life's usual rate. This rate will be based on the amount of insurance, class of risk and your age at date of policy issue; and
- Proof of good health is not required.

B. If the insurance ceases due to the termination or amendment of the Policy, an individual Life Insurance Policy can be issued. You must have been insured for at least 5 years under the Policy. The same rules as in a above will be used except that the face amount will be the lesser of:

1. The amount of your Group Life benefit under the Policy. This amount will be less any amount you are entitled to under any other group life policy issued by Reliance Standard Life Insurance Company or another insurance company; or
2. $5,000.00.

C. If the insurance reduces, as may be provided in the Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.

D. If you die during the time in which you are entitled to apply for an individual policy, Reliance Standard Life Insurance Company will pay the benefit under the Group Policy that you were entitled to convert. This will be done whether or not you applied for the individual policy.

E. Any policy issued with respect to A, B, or C above will be put in force at the end of the 90-day period in which application must be made.

Continuation of Insurance

Your insurance may be continued by payment of the premium beyond the date you cease to be eligible for this insurance, but not longer than:

1. Twelve (12) months, if due to illness or injury; or
2. One (1) month, if due to temporary lay-off or approved leave of absence.

Reinstatement

Your insurance may be reinstated if it was terminated while you were:

1. on an approved leave of absence; or
2. on temporary lay-off.

You must return to active work within six (6) months. You must also be a member of a class eligible for this insurance.

You will not be required to fulfill the eligibility requirements of the Policy again. The insurance will go into effect on the day you return to active work. If you return after having resigned or having been discharged, you will be required to fulfill the eligibility requirements of the Policy again.

If you return after terminating at your own request or for failure to pay premium when due, proof of good health must be approved by Reliance Standard Life Insurance Company before you may be reinstated.

Accelerated Benefit Rider

This benefit is payable to the Insured if, after having been covered under this Rider for at least 60 days, an Insured is Certified as Terminally Ill. In order for this benefit to be paid:

(a) The Insured must make a Written Request; and

(b) Reliance Standard Life Insurance Company must receive from any assignee or irrevocable Beneficiary their signed acknowledgement and agreement to payment of this benefit.

Reliance Standard Life Insurance Company may, at its option, confirm the terminal diagnosis with a second medical exam performed at Reliance Standard Life Insurance Company's expense. If the second medical exam produces a conflicting diagnosis, Reliance Standard Life Insurance Company would arrange for a third medical exam to be performed at its expense. The initial terminal diagnosis would then be honored only if it is confirmed by the third opinion.

Amount of the Accelerated Benefit

The Accelerated Benefit will be an amount equal to 75% of the Death Benefit applicable to the Insured under the Certificate on the date of the Certification of Terminal Illness, subject to a maximum benefit of $500,000.00. This benefit may be paid as a single lump sum or in installment payments mutually agreed by Reliance Standard Life Insurance Company and the Insured. The Accelerated Benefit is payable one time only for any Insured under this Rider.

Effect of Benefit

If an Insured becomes eligible for, and elects to receive this Accelerated Benefit, it will have the following effects:

(a) The Death Benefit payable for such Insured will be reduced by an amount equal to the Accelerated Benefit paid to such Insured. The amount of the Accelerated Benefit

us the corresponding Death Benefit will not exceed the amount that would have been aid as the Death Benefit in the absence of this Rider.

) Any amount of insurance that would otherwise be continued under a Waiver of remium provision will be reduced proportionately, as will the maximum Face Amount vailable under the Conversion Privilege.

isstatement of Age or Sex

ne Accelerated Benefit will be adjusted to reflect the amount of benefit that would ave been purchased by the actual premium paid at the correct age and sex.

ermination of an Individual's Coverage under the Accelerated Benefit ider

ne coverage of any Insured under this Rider will terminate on the first of the following:

) The date his/her coverage under the Policy terminates;

) The date of payment of the Accelerated Benefit for his/her Terminal Illness; or

) The date he/she attains age 75.

dditional Provisions

nis Rider takes effect on the Effective Date shown. It will terminate on the date the roup Policy terminates. It is subject to all terms of the Group Policy not inconsistent erewith.

ow Much Is Paid?

lease see the Schedule provided by your Employer.

ll covered Employees are eligible for the death benefit. Death Benefits automatically educe by the following percentages on the participant's 65th, 70th and 75th birthday. his benefit terminates at retirement. Percentages are based upon the principal mount in effect the day prior to the participant's 65th, 70th or 75th birthday whichever applicable:

eduction Percentage of Principal Amount	Effective
35%	65th Birthday
60%	70th Birthday
80%	75th Birthday

ACCIDENTAL DEATH AND DISMEMBERMENT

his benefit is fully insured through Reliance Standard Life Insurance Company (RSL).

ayment for dismemberment will be made to you. Payment for loss of life by accidental eath will be made to your Beneficiary. If more than one loss occurred as a result of ccidental means, payment shall be made for only the one loss for which the largest mount is payable. The loss must occur within three hundred sixty five (365) days after

the date of the accident. This benefit is provided to the Employee only. **No family members are eligible for this benefit.**

Accidental Death

An accidental death benefit is paid to beneficiaries of Employees who have completed the eligibility requirements. In the case of accidental death your AD&D principal sum is equal to the amount of your group term Life Insurance benefit, including any applicable reduction as set out above, on the day of loss.

Accidental Dismemberment

Member(s) means: hand, foot or eye.

Loss(es) must result directly and independently from injury, with no other contributing cause. Loss of a hand or foot means complete severance through or above the wrist or ankle joints. Loss of an eye means the total and irrecoverable loss of sight. Loss of speech means total and irrecoverable loss of function. Loss of Hearing means total and irrecoverable loss of hearing in both ears. Loss of a thumb and index finger means the complete severance through or above the metacarpophalangeal joint.

In the case of the following you are entitled to the principal sum as above: loss of life, loss of two or more members, loss of sight of both eyes, loss of speech and hearing.

In the case of the following you are entitled to one-half of the principal amount: loss of one member, loss of speech or hearing.

In the case of the following you are entitled to one-quarter of the principal amount: loss of thumb and index finger of the same hand.

Losses Not Covered by Life or AD&D Benefit

In addition to the General Exclusions and Limitations to all Plan Benefits set forth on page 31. This benefit does not cover losses in connection with any of the following:

Life Insurance:

Any loss while on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared)

Accidental Death and Dismemberment:

- An intentionally self inflicted injury;
- Any act of war, declared or undeclared;
- Sickness or disease which contributes to the loss (except infection which results from an accidental cut or wound).

YOUR BENEFICIARY

How to Name or Change a Beneficiary

To name a Beneficiary, simply complete the Beneficiary section of the enrollment form.

You may change your Beneficiary whenever you wish. To do so, merely complete a new form and make sure that it is sent in to the Benefits Manager at Chimes/DC. The change will take effect on the date you sign the new Beneficiary form. However, such change will not be in effect with regard to any payment made by the Plan until FCE receives the new Beneficiary form as submitted through Chimes/DC.

You Can Name More Than One Beneficiary

If you do so, you may also specify the share each is to receive of any benefits payable upon your death. If you do not specify, each Beneficiary will receive an equal share. If any of your beneficiaries are no longer alive upon your death, that person's share is divided equally among the surviving beneficiaries.

If You Do Not Name a Beneficiary

If you die without properly naming a Beneficiary, any benefits due as a result of your death will be paid in one sum in the following manner:

- 100% to any surviving spouse.
- If there is no surviving spouse, the benefits will be divided equally by any surviving children.
- If there is no surviving spouse or children, the benefits will be divided equally among the surviving parents.
- If there is no surviving spouse, children or parents, benefits will be divided equally among surviving brothers and sisters.
- If there are no surviving spouse, children, parents or brothers and sisters, the benefits will be paid to the executor or administrator of your estate.
- If your Beneficiary is a minor or incompetent, any benefits due as a result of your death shall be paid to the legally appointed guardian of your Beneficiary.

DEPENDENT'S LIFE INSURANCE BENEFITS

When an Insured Dependent dies, we will pay the applicable benefit shown in the schedule. If the Insured is deceased, then the benefits will be paid to the Insured's Beneficiary. Your eligibility for the dependent's death benefits stops when your coverage terminates or if you die. No Dependent Death Benefit will be paid in the event the decedent and the dependent were husband and wife and were both Employees at the time of the death of the decedent. A person may not have coverage both as an Insured and as a covered Dependent. Only one eligible spouse may cover the eligible children as Insured Dependents.

A conversion privilege is available when your Dependent's life insurance is no longer in force. For details concerning this option, please refer to the subsection titled "Conversion Privilege" under the Life Insurance Benefits section of this booklet.

HEARING AID BENEFIT

This is an Employee benefit that must be medically necessary and is not available to dependents.

Waiting Period

The appropriate Waiting Period for the Hearing Aid Benefit is six (6) months following the date of the participant's effective coverage in the Plan.

The Amount of the Benefit

The Schedule lists the maximum amount paid by the Plan and the Copayment required by the Employee. The benefit is available every three (3) calendar years and is based on the number of hours worked. Please refer to the Schedule.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

This Plan has an Employee Assistance Program for Employees and their eligible Dependents. Services include: Telephone crisis intervention, up to 4 sessions of in-person counseling, consultation, and referrals to appropriate resources for a variety of issues, including, but not limited to:

- Marital and family problems
- Emotional concerns, e.g., anxiety, depression and stress
- Substance abuse
- Job performance issues
- Financial concerns and referral/resources
- Dependent care issues

Legal Consultation Services: The initial in-person or telephone consultation is free. Subsequent visits or services are available at discounted rates depending on the type of issue. When you call, an attorney will explain your rights under the law and discuss your options for dealing with the problem. Examples of legal problems include:

- Housing and real estate matters
- Estate planning
- Family law, such as divorce, child custody and child support
- Car accidents and related matters
- Financial concerns
- Criminal and government matters

Excluded from this legal consultation service are consultations concerning the following:

- A lawsuit against your Employer
- Your personal business or commercial enterprise
- Medical/surgical second opinions
- Third-party advice

To Access: Call 1-800-424-4178. All calls are answered by professional, licensed clinicians 24 hours a day.

Please see the brochure included in your enrollment packet for a detailed description of this benefit.

FLU/HEPATITIS B VACCINES

Flu and Hepatitis B vaccines administered by Provider shall be an additional benefit covered at 100% for all Chimes/DC Employees. This benefit does not cover dependents.

PRESCRIPTION COVERAGE BENEFIT

Drugs (Defined below) purchased at a pharmacy and prescribed by a qualified medical provider for the necessary treatment of a disease or injury is covered. After satisfying the Copayments listed the benefits will be paid in accordance with the Schedule.

An Explanation of Certain Terms

1. Prescription Drugs (any of the following):
   a. A drug, biological, or compounded Prescription which, by Federal Law may be dispensed only by Prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without a Prescription."
   b. Disposable needles and syringes, injectable insulin and disposable diabetic supplies.
   c. Approved by the Food and Drug Administration for general use by the public.
2. Pharmacy means a licensed retail pharmacy.
3. Prescription means a written order issued by a medical provider.
4. Preferred Brand Prescription Drug (Brand Name) is a prescription drug that has been patented and is only produced by one manufacturer.
5. Non-Preferred Brand Prescription Drug (Brand Name) is a prescription drug that has been patented and is only produced by one manufacturer but the cost of the Non-Preferred is quite a bit higher than the Preferred Brand. This type of Prescription Drug has the highest Co-payment. To lower out-of-pocket costs, participants who are using these types of drugs may ask their physicians to change their prescriptions to a Preferred Brand Prescription Drug.
6. Generic Prescription Drug (Generic) is a prescription drug which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Patient DAW (Dispense as Written)

If there is a generically equivalent drug available for any brand medication and the Participant elects to have the brand name dispensed instead of the generic brand, the Participant shall be required to pay the difference between the brand name medications and the generic name in addition to the normal brand name Co-payment. If Physician has indicated DAW (Dispense as Written) for the prescription, the Participant is not penalized. If there is no generic bio-equivalent available, there is no additional cost to the Participant.

Specialty drugs: Certain specialty drugs will require the Participant to pay 20% of the cost of the drug. These are very high cost drugs used to treat relatively uncommon medical conditions. These specialty drugs include:

❖ Rebetron ❖ Lupron Depot ❖ DDAVP ❖ Zyprexa ❖
Neupogen

When you go to the Pharmacy

Always make sure that you present your insurance identification card to the pharmacist and to satisfy your Co-payment which is indicated on the Schedule.

In the event that you forget your insurance identification card and are charged full retail price for your prescription at the time of purchase **please return to the pharmacy with your insurance identification card as soon as possible** in order for the pharmacy to reprocess your purchase and to refund any overpayment you may have made.

Please remember that if you use a non-participating pharmacy you will be liable for the entire cost of the prescription.

Injectable Drugs

Prescribed injectable medications obtained at a member pharmacy prescribed for the necessary treatment of illness or injury, are covered by the Prescription Drug Benefit. Injectable medications that are not administered by a physician during an office visit or other medical facility shall be covered under the Physician Visit Benefit.

Mail Service for "Maintenance" Medications

To enroll in the Mail Service Pharmacy and to place your initial order, you must fill out a Mail Service Pharmacy Enrollment Form. You may obtain these forms by calling Express Scripts at 1-800-451-6245 or enrolling online at www.express-scripts.com.

When placing your order, please include your original prescription and the corresponding Co-payment indicated on the Schedule.

Prescriptions filled through the mail service may be dispensed for up to a ninety (90) day supply or 100 units, whichever is greater (if your physician so indicates on the prescription). The mail service program also provides the convenience of "at home" delivery via UPS or U.S. Mail at no cost to the participant.

If you have refills left on maintenance medications that you were ordering through your previous mail service provider, simply send the reorder (including the name of the drug) to Express Scripts along with your physician's telephone number and Express Scripts will call and transfer your remaining refills to the Express Scripts Mail Service Facility.

If your previous mail service provider will not transfer your prescription, you must contact your Doctor to obtain a new prescription and you must then submit the new prescription to the Express Scripts Mail Service Facility.

Expenses Not Covered Under This Benefit

In addition to the General Exclusions and Limitations to all Plan Benefits as set forth starting on page 31 no benefits are payable for:

- For any drug entirely consumed at the time and place it is prescribed
- For the administration or injection of any drug.
- For any refill of a drug if it is more than the number of refills specified by the Prescriber

- For any refill of a drug dispensed more than one year after the latest Prescription for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any contraceptive drug (other than oral contraceptives) regardless of the intended therapeutic use.
- For any drug provided by, or while the person is an inpatient in, any healthcare facility.
- Vitamins and vitamin prescriptions (other than legend vitamins).
- For nutritional or dietary supplements or weight control.
- DESI drugs (drugs determined by the U.S. Food and Drug Administration as lacking in substantial evidence of effectiveness).
- For any smoking cessation aids or drugs.
- Any drug used for Cosmetic purposes.
- Infertility drugs, regardless of intended use.
- For appetite suppressants.
- Drugs, which are not prescribed by a Provider, except injectable insulin.
- Drugs dispensed due to an injury or an illness which is employment-related or which is covered under Worker's Compensation Law, Occupational Disease Laws or any similar laws.
- Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substance unless specifically covered by this benefit.
- Prescription drugs which may be properly received without charge under local, state or federal programs.
- Non-prescription drugs.
- Retin A, except for children through age 18
- Growth hormones; and

ou are required to turn in your insurance identification card to the Employer, or FCE Benefit Administrators, at the time your coverage terminates. If you fail to so and you use your insurance identification card after your coverage rminates, you will be responsible for all of the costs associated with such use. addition, if you use your card after your coverage terminates, such action nstitutes fraud, and you may be liable for both civil and criminal penalties for ich unauthorized use. Either FCE Benefit Administrators or your Employer, or th, will seek legal redress of such unauthorized use of your insurance entification card, to the maximum extent permitted.

MATERNITY

r the purpose of computing medical benefits, maternity is treated as any other ndition requiring treatment for female Employees or eligible dependent wives. ependent children are not covered under the maternity benefit.) There are specific gical benefits referred to in maternity cases. While the Schedule of Surgical nefits starting on page 61 is only a partial listing and does not contain maternity ecific procedures, the FCE claims administration staff will gladly discuss any aternity related claim specific surgical benefits, if requested.

opal fees charged for maternity will be computed as follows:

- The amount charged for the delivery alone will be requested from the obstetrician.
- This amount will be considered as outlined in the Schedule of Surgical Benefits.
- The amount of the global fees will then be reduced by the amount charged for the delivery and the remaining amount will be considered for benefits under the doctor's visit expense benefit.

Eligible maternity expenses are covered whether incurred in a hospital or birthing center. For the purposes of this benefit, a birthing center is defined as a free standing facility that:

- Is licensed as a birthing center in the jurisdiction it is in.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for services and supplies it provides.
- Is directed by at least one physician who is a specialist in obstetrics and gynecology.
- Has a physician or certified nurse-midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, in the delivery and recovery rooms, full time skilled nursing services directed by an R.N. or certified nurse-midwife.
- Provides, or arranges with a facility in the area for, diagnostic x-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery.
- This includes episiotomies and repair of perinea tear.
- Is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life; if complications arise during labor, and if a child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low risk pregnancies.
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by M.D's or D.O's who do not own or direct the facility.
- Keeps a medical record on each patient and child.

DISMISSAL WAGE / UNEMPLOYMENT BENEFIT (DUB)

This section of your Summary Plan Description (SPD) booklet applies to Employees who participate in the Dismissal Unemployment Benefit (DUB). In order to determine

ether you are a DUB participant, please refer to the Schedule of Benefits provided by ur Employer. If the applicable Schedule of Benefits includes a DUB as part of the an, then you are a DUB participant, in which case this SPD section applies to you. herwise, this SPD section does not apply.

e purpose of the Dismissal Wage/Unemployment Benefit (DUB) is to provide a loss income benefit to a participant who suffers an unforeseen dismissal from ployment and/or who actually experiences a period of unemployment, provided rtain requirements are met.

nding of the DUB

nployer contributions received by the Plan shall be allocated to the participants' counts in the Plan. Contributions may vary as a result of work schedule variations, d allocations to employee's accounts may be calculated on an individual or group sis. Each employee shall have a separate DUB account. The contributions shall be ntributed to the Plan's Trust and shall be invested into an interest-bearing account or rtificate of deposit maintained by any federal or State chartered bank or savings and an association.

equirements for Receiving the DUB Benefit

order to qualify to receive this DUB benefit, you must suffer a termination of nployment as a result of contract termination or reduction in the work force ("layoff"), voluntary termination (with or without cause), or employee voluntary termination of nployment ("quitting") with a period of unemployment of at least twenty-four hours lowing termination of employment. If you return to work for the same Employer within days of termination, you will not qualify to receive a distribution, and your DUB count will continue to be administered as though there was no break in service. rther, termination of employment must be for reasons other than willful misconduct.

our Employer will notify the Third Party Administrator (FCE Benefit Administrators, c.) of your termination of employment in its weekly employee status report to the Third arty Administrator. Upon notification of your termination of employment, the Third arty Administrator will send to you a Benefit Request form. If you fail to return a mpleted Benefit Request form to the Third Party Administrator within 30 days from e date the Benefit Request form has been mailed to you, a second Benefit Request rm will be mailed. If you fail to return the completed second Benefit Request form to e Third Party Administrator within 60 days from the date the second Benefit Request rm has been mailed to you, the Dismissal Wage/Unemployment Benefit will be rfeited. Such forfeitures are reallocated to all remaining participants in the Plan, on a r capita basis.

fter the Third Party Administrator receives the necessary paperwork and all Employer ntributions for you, you can expect to receive a lump sum distribution of the DUB nefit within 60 days. (Note: it is not 60 days from termination of employment, but 60 ys from the date the Third Party Administrator has everything it needs to process ur claim, which may take a total of 90 to 120 days from termination.)

though the Plan usually pays benefits in a lump sum, if you meet the eligibility quirements for unemployment benefits in your State (as determined by the Third arty Administrator), then the Plan benefit may (depending on the circumstances

surrounding your termination of employment) be treated as a Supplemental Unemployment Benefit and will be paid to you in installments rather than in a lump sum.

Amount of Benefit

A number of factors affect the amount of your benefit upon termination of employment. Factors affecting the amount of benefit include the amount of monthly contributions to your account and your length of employment. The amount of the DUB benefit is the cash balance of your DUB account increased by earnings and forfeitures, and decreased by administrative expenses. Because the actual value of the DUB benefit is based on the above factors, the precise amount of benefit available at distribution can only be accurately determined at that time. In any event, the benefit cannot exceed twice the annual compensation you received in the year preceding termination.

Forfeiture of the Benefit

There is no guarantee that you will achieve eligibility for a DUB benefit distribution. The DUB benefit is forfeited under the following circumstances:

1) Dismissal from employment for willful misconduct. *
2) Voluntary termination of employment with no period of unemployment.
3) Death

* willful misconduct is an act or omission involving dishonesty or dereliction of duty, a transgression of an established and definite rule or criminal conduct (as determined by the Third Party Administrator). The act or omission may be active or passive, and must be willful in character and beyond simple negligence. Examples of willful misconduct include but are not limited to; walking off the job without proper notice or permission, failing to report to work without proper notice, disregarding or challenging instructions from a supervisor or company policy, etc..

Benefits are also forfeited if the Third Party Administrator does not hear from you within 60 days of the mailing date of the second Benefit Request form letter, as stated in the section above titled "Requirements for Receiving the DUB Benefit". Forfeitures are reallocated to all remaining participants in the Plan, on a per capita basis.

Tax Consequences of the DUB Benefit

The DUB benefit is not taxable while you are employed. Contributions made on your behalf by your Employer while you are employed are free of income and payroll taxes. The DUB benefit becomes taxable to you upon your receipt of the DUB benefit.

If the benefit is paid out as Dismissal Wage, the Third Party Administrator must withhold from your gross DUB benefit amount Employee income and payroll taxes (i.e., FICA, Medicare, FUTA), before disbursing the net proceeds to you. If the benefit is paid out as a Supplemental Unemployment Benefit (SUB), the net disbursement will be free of all Federal payroll related taxes, however, the disbursement may be subject to Federal, State and local income tax withholding. You will receive a W-2 form to include with your annual tax filing. The circumstances surrounding your separation from the company at the time you terminate employment and your eligibility to receive unemployment benefits from your State will determine whether you receive the DUB benefit as a Dismissal Wage/Unemployment Benefit or a Supplemental Unemployment Benefit. The Benefit Request form that you will receive upon the Third Party Administrator's

ication of your termination will allow you to indicate which benefit you are eligible

3 Claim Considerations

ails concerning the claims procedure for non-health claims (such as a DUB benefit n) is located in the section of this SPD titled "Claims Procedures."

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

ecial Rights upon Childbirth. Group health plans and health insurers generally may , under federal law, restrict benefits for any hospital length of stay in connection with dren for the mother or newborn child to less than 48 hours following a vaginal ivery, or less than 96 hours following a cesarean section. However, federal law nerally does not prohibit the mother's or newborn's attending provider, after nsulting the mother, from discharging the mother or her newborn earlier than 48 urs (or 96 hours as applicable). In any case, plans and insurers may not, under leral law, require that a provider obtain authorization from the plan or the insurer for scribing a length of stay not in excess of 48 hours (or 96 hours).

WOMAN'S HEALTH AND CANCER RIGHTS ACT OF 1998

e Plan covers medical and surgical benefits for mastectomies. Effective January 1, 99, this coverage includes:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, or
- Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

his coverage is subject to the Plan's Coinsurance provision and benefit limits.

GENERAL LIMITATIONS AND EXCLUSIONS

Charges for any service, treatment, medicine or supply which:

a. is not medically necessary for the treatment of an injury or illness; or

b. is not recommended by a Physician; or

c. is not considered to be safe or effective, or is considered to be experimental or investigational (based on generally accepted current professional standards and criteria for evaluation and review of: new techniques and treatments, or new applications of older technologies and treatments).

For expenses resulting from or in connection with an illness or injury arising out of, or in the course of, any employment for wage or profit or for expenses resulting from or in connection with an illness or injury for which the covered person is entitled to benefits under any Worker's Compensation or similar law.

Charges in excess of the Prevailing Rate for the services, treatments or supplies in the locality where rendered or furnished.

4. Charges in excess of any maximum benefit limit which has been reached, for the rest of the period of time to which such limit applies.

5. For charges incurred in a hospital or facility owned or operated by the United States Government unless applicable by law.

6. Charges incurred due to intentional self-inflicted injury or attempted self-destruction. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental) condition.

7. To the extent that payment under the plan is prohibited by any law of the jurisdiction in which the covered person resides at the time the expenses are incurred.

8. Charges for communications, transportation or travel time and the local use of professional ambulance service.

9. For charges, which the covered person is not legally required to pay, or for charges which would not have been made if no health benefit plan had existed.

10. Charges as a result of voluntary participation in an assault, felony, insurrection, or riot.

11. Charges for radial keratotomy or any other surgical procedure performed to correct myopia (nearsightedness) or hyperopia (farsightedness).

12. Charges for the purchase or rental of air conditioners, air purifiers, motorized transportation equipment, escalators or elevators, swimming pools, waterbeds, exercise equipment or other similar items or equipment.

13. Charges for any care, treatment or service given by a close relative or rendered in any facility owned or operated by a close relative.

14. Charges for Elective Treatment or Surgery or for sterilization reversal procedures or birth control measures (other than sterilization). Vasectomy and tubal ligation are covered only in the Major Medical Plan.

15. Charges for treatment or surgery to change gender or to improve or restore sexual function (except when such sexual dysfunction is the direct result of a primary organic illness or accidental bodily injury which occurs while covered under this Plan).

16. Charges for artificial insemination, in vitro or in vivo fertilization, or similar services or procedures, for the purpose of impregnation, which do not treat or correct a physical condition causing infertility.

17. Weekend charges incurred for Hospital confinements that start on Friday, Saturday or Sunday, unless:

    a. the attending physician certifies that such week-end admission is medically necessary; or

    b. such week-end Hospital confinement is in connection with a surgery scheduled for the day that next follows the date of admission (Saturday, Sunday or Monday).

18. Charges for the treatment of obesity, unless diagnosed as Endogenous Morbid Obesity by a Physician.

9. Charges for any home health care services or supplies:

a. not included in the home health care treatment plan; or

b. provided for persons in the household other than the patient; or

c. provided by a person who normally resides in the patient's home or is a member of the patient's household, or is a close relative.

10. Charges for any custodial care, education or training (such as bathing or dressing; assistance with mobility, feeding or taking oral medicines) regardless of:

a. who recommends, provides or directs care; or

b. where the care is provided; or

c. whether or not the patient can be or is being trained for self-care.

11. Charges for any medical or hospital care in connection with dental treatment unless:

a. such dental treatment is covered under Dental Benefits, if Dental Benefits are included on the Schedule;

b. such care is in connection with a congenital defect or malformation or birth abnormality of a newborn child.

12. Charges for orthodontics or any other dental treatment of the teeth or gums, whether or not in connection with a jaw condition, unless:

a. required for repair or replacement of sound natural teeth damaged by an accidental dental injury (caused by any sudden and unexpected impact from outside the oral cavity) sustained while covered under this Plan and performed while so covered and within 12 months following such injury; or

b. in connection with a congenital defect or malformation or birth abnormality of a newborn child; except: such charges will not be covered under these medical benefits for a chewing injury, or if Dental Benefits are included on the Schedule and such treatment is covered and payable under such Dental Benefits.

13. Charges for maternity coverage for a dependent child.

14. Charges by any provider of care or service who or which is not properly licensed or approved as required.

15. If two or more medically necessary surgical procedures are performed through the same incision during the course of a single operation, payment for the first surgical procedure will be at 100% of the fee schedule; subsequent procedures are reduced (each) to 50% of reasonable and customary charges allowed for your level of benefits under the Plan. The percentage of payment for reasonable and customary charges for the second surgical procedure will be reduced by 30%. The percentage of payment for reasonable and customary charges for the third surgical procedure will be reduced by 55%.

16. For charges made which are:

a. For unnecessary care or treatment.

b. For experimental procedures, devices or medications unless approved by the Re-insurer.

27. For expenses resulting from or in connection with an injury or illness resulting from war or any act of war declared or not, or sustained while in any of the armed forces of any country or international authority; or sustained while engaged in any armed conflict.

28. For hospital expenses when a covered person is hospitalized mainly for bed rest, convalescent, custodial or institutional care, rehabilitation or physical therapy.

29. For expenses incurred in connection with cosmetic surgery unless:

a. The surgery is necessary for repair or alleviation of a disfigurement causing functional disorder resulting from an injury sustained while covered under the Plan.

b. The surgery is incidental to or follows surgery resulting from infection or other diseases of the involved part.

c. The surgery is necessary because of congenital disease or anomaly, which has resulted in a functional defect.

d. The surgery is necessary to correct a severe physical functional defect caused by disease, provided that alternative modes of treatment, if any exist, have been tried first. No claim reimbursement consideration will be given to such expenses unless the claimant submits advance documentation from the physician recommending the procedure. Documentation must include a detailed description of the defect and the resulting functional handicap. The report should give details of the results, effective or not, of the modes of treatment that have been tried. The report must justify the need of surgical correction. Finally, the report must include a description of the procedure, the physician's costs, the number of days of hospitalization required and any follow-up treatment. The Plan Administrator reserves the right to require a second and, in the case of conflict, a third opinion.

30. For expenses related to speech, visual, or occupational therapy, multi-phasic testing or general health examinations, psychiatric testing done to determine vocational aptitudes and psychiatric testing for any purpose that could be provided through the public school system, unless otherwise covered.

31. Any charges whatsoever that were incurred prior to the effective date of your eligibility or after your coverage ceases.

Any charges incurred as a result of elective abortion.

Charges in connection with Temporomandibular Joint syndrome (TMJ).

Examinations for the purpose of obtaining or maintaining employment licenses, school admissions or participation in sport activities.

Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

COORDINATION OF BENEFITS

ordination of Benefits sets out rules for the order of payment of Covered Charges en two or more plans—including Medicare—are paying. When a Covered Person is vered by this Plan and another plan, or the Covered Person's Spouse is covered by s Plan and by another plan or the couple's Covered children are covered fewer than o or more plans, the plans will coordinate benefits when a claim is received.

a plan that pays first according to the rules will pay as if there were no other plans olved. The secondary and subsequent plans will pay the balance due up to 100% of total allowable expenses.

nefit plan. This provision will coordinate the medical and dental benefits of a benefit n. The term benefit plan means this Plan or any one of the following plans:

Group or group-type plans, including franchise or blanket benefit plans.

Blue Cross and Blue Shield group plans.

Group practice and other group prepayment plans.

Federal government plans or programs. This includes Medicare.

Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

No Fault Auto Insurance, by whatever names it is called, when not prohibited by law.

owable Charges

r a charge to be allowable it must be a Usual and Reasonable Charge and at least t of it must be covered under this Plan.

the case of an HMO (Health Maintenance Organization) or other in-network only ns: This Plan will not consider any charges in excess of what an HMO or network vider has agreed to accept as payment in full. Also, when an HMO or network plan primary and the Covered Person does not use an HMO or network provider, this Plan l not consider as an allowable charge any charge that would have been covered by HMO or network plan had the Covered Person used the services of an HMO or work provider.

the case of service type plans where services are provided as benefits, the sonable cash value of each service will be the allowable charge.

tomobile Limitations

ien medical payments are available under vehicle insurance, the Plan shall pay cess benefits only, without reimbursement for vehicle plan deductibles. This Plan

shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit Plan Payment Order

When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the Allowable Charge:
    a. The benefits of the plan which covers the person directly (that is, as an Employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").
    b. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
    c. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA Beneficiary.
    d. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
        i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in the year.
        ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
    e. When a child's parents are divorced or legally separated, these rules will apply:
        i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
        ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

iii. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

iv. If the specific terms of the court decree state that the parent shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced

f. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

3. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A & B, regardless of whether or not the person was enrolled under both of these parts.

4. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit will pay first and this plan will pay second.

Claims Determination Period

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another plan/insurer or any organization or person. This information may be given or obtained without the consent or notice to any other person. A Covered Person will give the Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. The repayment will count as a valid payment under this Plan.

Right of Recovery

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

HOW TO FILE A CLAIM FOR BENEFITS

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment, such as an out-of-network, a Dental or Vision Claim, that person must:

1. Obtain a Claim form from the Personnel Office Benefit Manger or the Plan Administrator.
2. Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
3. Have the Physician or Dentist complete the provider's portion of the form.
4. For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW.
    a. Name of Plan
    b. Employees name
    c. Name of patient
    d. Name, address, telephone number of the provider of care
    e. Diagnosis
    f. Type of services rendered, with diagnosis and/or procedures codes
    g. Date of service
    h. Charges

CLAIM PROCEDURES

Claims should be filed with the Claims Administrator within 120 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined unless it was not reasonably possible to submit the claim in that time. In any event, the claim must be submitted no later than one (1) year from the date incurred. All claims received later than one (1) year will be declined.

Please note that the following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures Regulations and should be interpreted accordingly. In the event of any conflict between this summary and those Regulations, the Regulations shall control. In addition, any changes in those Regulations will apply to the Plan automatically effective as of the date of those changes.

To receive Plan benefits, the claimant must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to the claimant.

The Plan reserves the right to have a Plan Participant seek a second opinion.

Initial Claims

Initial claims for Plan benefits are made to the Claim Administrator (FCE). The Claim Administrator will review the claim itself or appoint an individual or an entity to review the claim, following these procedures:

(a) Non-Health Benefit Claims. In the case of a claim that is not a health claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the reviewer before the end of the 90 day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond the day which is 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the Claimant's claim is for urgent care health benefits, the reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the reviewer will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could be adequately managed with the care or treatment which is the subject of the claim.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment of termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the reviewer will notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain

a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. In the case of a health benefit claim not described above:

a. In the case of a pre-service health benefit claim, the reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. If, due to special circumstances, the reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the reviewer expects to make its decision. Under no circumstances may the reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

b. In the case of a post-service health benefit claim, the reviewer will notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the reviewer expects to make its decision. Under no circumstances may the reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the

required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment of services which the Claimant has already received.

(c) Manner and Content of Denial of Initial Claims. If the reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

(i) A description of the specific reasons for the denial;

(ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;

(iii) A description of any additional information that the Claimant must provide in order to perfect the claim (including an explanation of why the information is needed);

(iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial; and

(v) A statement of the Claimant's right to bring a civil action under a Federal law called "ERISA" following any denial on review of the initial denial.

In addition, in the case of a denial of health benefits, the following will be provided to the Claimant:

(i) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that a copy will be provided without charge upon request); and

(ii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, and explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that an explanation will be provided without charge upon request).

(In the case of an adverse benefit determination concerning a health claim involving urgent care, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with the Section is furnished not later than 3 days after the oral notification.)

Reviews of Initially Denied Claims

If a claim is submitted for Plan benefits and it is initially denied under the procedures described above, the claimant may request a review of that denial under the following procedures.

(a) Non-Health Benefit Claims. In the case of benefits other than health benefits, a request for review of a denied claim must be made in writing to the Claim Administrator within 60 days after receiving notice of the initial denial of the claim. The decision on review will be made within 60 days after the Claim Administrator's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than one hundred twenty (120) days after receipt of a request for review.

The reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Claim Administrator. The reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health Benefit Claims. A Claimant whose initial claim for health benefits is denied may request a review of that denial by submitting the request in writing to the Claim Administrator no later than 180 days after the Claimant receives the notice of an adverse benefit determination. In addition to providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary of appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination,

without regard to whether the advice was relied upon in making the review determination.

(iv) In the case of a requested review of a denied initial claim involving urgent health care, the review process shall meet the expedited deadlines described below. The Claimant's request for such an expedited review may be submitted orally or in writing by the Claimant and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. In case of urgent care health claims, the reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of the initial adverse determination by the Plan.

(ii) Other Health Benefit Claims.

a. In the case of a pre-service health claim, the reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of the Claimant's request for review of the initial adverse determination.

b. In the case of a post-service health claim, the reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after receipt by the Plan of the Claimant's request for review of the initial adverse determination.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial determination, the reviewer will provide the Claimant a written or electronic notice that includes:

(i) a description of its decision;

(ii) a description of the specific reasons for the decision;

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;-

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in

the Plan's files which is relevant to the Claimant's claim for benefits;

(v) a statement describing the Claimant's right to bring an action for judicial review under ERISA &502(a);

(vi) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(vii) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary, the period for making the determination will be "frozen" from the date the notification requesting the additional information is sent to the Claimant until the day the Claimant responds.

Plan's Failure to Follow Procedures

If the Plan fails to follow the claims procedures described above, a Claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Insured Benefits and State Law

With respect to any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supercede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action my be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Claim Administrator has been rendered (or deemed rendered).

SUBROGATION

1 This Provision Applies

Covered Person may incur medical or dental charges due to injuries which may be ed by the act or omission of a Third Party or a Third Party may be responsible for ient. In such circumstances, the Covered person may have a claim against that l party, or insurer, for payment of the medical or dental charges. Accepting benefits r this Plan for those incurred medical or dental expenses automatically assigns to Plan any rights the Covered Person may have to recover payments from any Third / or insurer. This Subrogation right allows the Plan to pursue any claim which the ered Person has against any Third Party, or insurer, whether or not the Covered ion chooses to pursue that claim. The Plan may make a claim directly against the d Party or insurer, but in any event, the Plan has a lien on any amount Recovered he Covered Person whether or not designated as payment for medical expenses. lien shall remain in effect until the Plan is repaid in full.

Covered Person

- Automatically assigns to the Plan his/her rights against any Third Party or insurer when this provision applies; and
- Must repay to the Plan the benefits paid on his/her behalf out of the Recovery made from the Third Party or insurer.

lount Subject to Subrogation or Refund

e Covered Person agrees to recognize the Plan's right to Subrogation and mbursement. These rights provide the Plan with a 100%, first dollar priority over any d all Recoveries and funds paid by a Third Party to a Covered Person relative to the ury or sickness, including a priority over any claim for non-medical or dental charges, orney fees, or other costs and expenses. Accepting benefits under this Plan for those curred medical or dental expenses automatically assigns to the Plan any and all rights e Covered Person may have to recover payments from any Responsible Third Party. rther, accepting benefits under this Plan for those incurred medical or dental penses automatically assigns to the Plan the Covered Person's Third Party Claims.

otwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well s the rights assigned to it, are limited to the extent to which the Plan has made, or will ake, payments for medical or dental charges as well as any costs and fees ssociated with the enforcement of its rights under the Plan. The Plan reserves the ght to be reimbursed for its court costs and attorney's fees if the Plan needs to file suit order to recover payment for medical or dental expenses from the Covered Person. lso, the Plan's right to Subrogation still applies if the recovery received by the Covered erson is less than the claimed damage, and, as, a result, the claimant is not made hole.

Vhen a right of Recovery exists, the Covered Person will execute and deliver all equired instruments and papers as well as doing whatever else is needed to secure he Plan's right of Subrogation as a condition to having the Plan make payments. In ddition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

The Plan will not be subject to any "make whole" or other subrogation rule. **Conditions Precedent to Coverage**

The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person who refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of injury or sickness caused by a Responsible Third Party until after the Covered Person or his authorized legal representative obtains valid Court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Recovery From Another Plan Under Which the Covered Person is Covered

This right of Refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of the Plan Administrator

The Plan Administrator has a right to request reports on and approve of all settlements.

ASSIGNMENT OF BENEFITS

As a convenience to participants of the FCE administered Plan, assignment of benefits to providers of services is required. Benefits provided for a specific service shall be paid to the provider of that specific service except when the claim is accompanied by a paid receipt.

It is the responsibility of the participant to give proper notice of other coverage when filing a claim with FCE.

Anytime you are hospitalized or receive any form of medical care, it is your responsibility to inform the hospital or other health care provider of the full extent of your coverage spelled out in this booklet.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of Contributions will be made when the error or delay is discovered.

If, due to clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of the overpayment will be deducted from future benefits payable.

AMENDMENT OF PLAN

nployer shall have the right to modify or amend the Plan from time to time, in whole or part, provided that no amendment shall be made which shall divert Trust Funds to rposes other than for the exclusive benefit of participants and their beneficiaries. ich amendments shall be made by the action of a majority of a quorum of the Board Directors of Employer, which action shall be written. Plan Administrator, upon asonable notice to Trustee and Employer shall have the right to modify or amend the an from time to time if necessary to conform to the requirements of ERISA, SCA or her applicable law or to insure Plan viability. Plan Amendments shall be distributed to articipants within a reasonable period of time of enactment. All amendments to this an shall be made in writing and made pursuant to the Plan. All other purported nendments shall be null, void and of no effect. Oral amendments of the Plan are not ermitted.

TERMINATION OF PLAN

he Plan shall remain in existence from year to year unless written termination one arty gives notice to the other parties at least 60 days but not more than 90 days prior) the anniversary date of effective coverage under this Plan.

COBRA CONTINUATION OF MEDICAL BENEFITS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), equires that most Employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA" continuation coverage") in certain nstances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA Continuation Coverage?

COBRA continuation coverage is group health plan coverage that an Employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non COBRA beneficiaries).

Who is a Qualified Beneficiary?

In general, a Qualified Beneficiary is:

I. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

II. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

III. A covered Employee who retired on or before the date substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a Beneficiary under the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a non resident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

I. The death of a covered Employee

II. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

III. The divorce or legal separation of a covered Employee from the Employee's Spouse.

IV. A covered Employee's enrollment in the Medicare program.

V. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

VI. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of

bankruptcy of the Employer, any substantial elimination of coverage under the Plan urring within 12 months before or after the date the bankruptcy proceeding mences), the persons losing such coverage become Qualified Beneficiaries under BRA if all the other conditions of the COBRA law are also met. Any increase in ntribution that must be paid by a covered Employee or the Spouse, or a Dependent d of the covered Employee, for coverage under the Plan that results from the currence of one of the events listed above is a loss of coverage.

e taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not nstitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does : return to employment at the end of the FMLA leave and all other COBRA ntinuation coverage conditions are present. If a Qualifying Event occurs, it occurs on : last day of FMLA leave and the applicable maximum coverage period is measured m this date (unless coverage is lost at a later date and the Plan provides for the tension of the required periods, in which case the maximum coverage date is easured from the date when the coverage is lost.) Note that the covered Employee d family members will be entitled to COBRA continuation coverage even if they failed pay the Employee portion of premiums for coverage under the Plan during the FMLA ave.

/hat is the Election Period and How Long Must it Last?

n election period is the time period within which the Qualified Beneficiary can elect OBRA continuation coverage under the Employer's Plan. A Plan can condition vailability of COBRA continuation coverage upon the timely election of such coverage. n election of COBRA continuation coverage is a timely election if it is made during the lection period. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end efore the date that is 60 days after the later of the date the Qualified Beneficiary would ose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his/her right to elect COBRA continuation coverage.

s a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of Their Occurrence of a Qualifying Event?

n general, the Employer or Plan Administrator must determine when a Qualifying Event as occurred. However, each covered Employee or Qualified Beneficiary is responsible or notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.
- The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of; the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

s a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of a loss of coverage resulting from a Qualifying Event and ending not before the earliest of the following dates:

I. The last day of the applicable maximum coverage period.

II. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

III. The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

IV. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

V. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

VI. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

   a. (I) 29 months after the date of the loss of coverage as the result of a Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

   b. The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a qualified Beneficiary.

What are the Maximum Coverage Periods for COBRA Continuation Coverage?

maximum coverage periods are based on the type of the Qualifying Event and the tus of the Qualified Beneficiary, as shown below.

I. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the loss of coverage resulting from the Qualifying Event if there is not a disability extension or 29 months after the loss of coverage if there is a disability extension.

II. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

   a. 36 months after the date the covered Employee enrolled in the Medicare program; or

   b. 18 months (or 29 months, if there is a disability extension) after the loss of coverage resulting from the covered Employee's termination or reduction of hours of employment.

III. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after loss of coverage resulting from the death of the retired covered Employee.

IV. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

V. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the loss of coverage resulting from the Qualifying Event.

Under What Circumstances Can the Maximum Coverage Period be Expanded?

f a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the Qualifying Event.

How Does a Qualified Beneficiary Become Entitled to a Disability Extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with

notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

Can a Plan Require Payment for COBRA Continuation Coverage?

Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled Qualified Beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that Qualified Beneficiary.

Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Monthly Installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is the Timely Payment for Payment for COBRA Continuation Coverage?

Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a Qualified Beneficiary be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

QUESTIONS REGARDING COBRA - If you have any questions regarding notification of your COBRA rights, please feel free to contact FCE at:

FCE Benefit Administrators, Inc.
COBRA Administration
445 Recoleta, Suite 100
San Antonio, TX 78216-7520
210-349-9801 or 800-899-WELL
TTY Phone Number for Hearing Impaired
1-877-319-7145

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Plan Participant in this FCE Administered Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrators office and at other specified locations (such as worksites) all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or Dependents may have to pay for such coverage.
- Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or Dependent has Creditable Coverage from another plan. The Employee or Dependent should be provided a Certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect

COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he/she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in a state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, he/she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his/her rights under ERISA.

If it should happen that plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or may file a suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him/her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he/she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his/her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA),

that Plan Participant should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, at 200 Constitution Avenue, N.W., Washington, DC. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GLOSSARY OF INSURANCE TERMS

A

AD&D—a supplemental group Life Insurance plan which pays a multiple of the group term life face amount, based on accidental death or specified dismemberment. This coverage may be written on a 24-hour basis, covering both occupational and non-occupational accidents.

Administrator—a person who is designated to be responsible for the proper operation and administration of a plan. When the plan sponsor does not designate a person for this duty, then ERISA considers the plan sponsor to be the plan administrator

B

Beneficiary—the person entitled to receive benefits under a plan, including the covered Employee and his or her dependents.

C

Certificate—a document that describes insurance coverage.

Certificate of Creditable Coverage—initially for all Employees, and each time a new Employee applies for coverage, you will collect and submit to us any evidence of prior coverage. This helps us administer your plan's pre-existing conditions limitations on benefits correctly. Your compliance is required by HIPAA.

Claim—an insured's request for reimbursement from an insurance company or plan for covered medical expenses.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)—a federal law that requires most Employers to allow eligible Employees and their beneficiaries to continue to self pay for their coverage after it normally terminates for up to 18, 24, 29 or 36 months.

Contribution – shall mean the Fringe Benefit Amounts, which Employer is required to pay for the Employees benefits by the Contracting Agency, as amended from time to time. Contribution shall also mean amounts, which Employer is required to pay for its Employees benefits, which are agreed upon between the Employer/Sponsor, Trustee and TPA for the Employees who are not governed or regulated by a Contracting Agency. Contribution shall also mean the total hourly, weekly or monthly actual cost of Employee benefits, which may differ from the amount Employer, is paying or is required to pay for its Employees.

Coordination of Benefits (COB)—a contractual provision to prevent an insured from receiving duplicate benefits from two or more group plans and profiting from over-insurance.

Copayment – a small charge paid at the time a medical service is received. It does not accumulate towards a plan's out-of-pocket maximum and is designed to discourage utilization.

CPT-4 Coding (Current Procedural Terminology) - a coding system consisting of five-digit codes that correspond to medical services rendered in physician's offices, outpatient clinics or ambulatory centers.

D

ate of Hire – the date the Employee first provides services on a Plan covered ntract.

E

ffective Date – the date that coverage begins. For initially covered Employees, the ffective date is January 1, 2003. For subsequently covered Employees, the effective ate is two months following the date that the Employee first renders services on behalf the Employer.

mployee - any Employee on whose behalf an Employer has agreed to make ontributions to the FCE Administered Health & Welfare Plan of that company.

mployee Assistance Programs (EAPs)—mental health counseling services that are ometimes offered by insurance companies or Employers.

mployer - any Employer of Employees for whom FCE is the plan administrator and ho has agreed in writing to be bound by the terms and conditions of the Trust greement establishing the FCE Administered Health & Welfare Plan of that company.

ERISA (Employee Retirement Income Security Act of 1974)—a federal law which riginally set minimum standards for funding, vesting and termination of Employer-ponsored pension plans. ERISA also contains provisions to protect the interests of articipants and beneficiaries in welfare plans. Welfare plans must be in written form, describe the benefits and name the persons responsible for the operation of the plan.

Eligible Expense(s)—the portion of the medical care provider's services that is covered for payment under the terms of the health plan or insurance contract.

Exclusion—specific conditions or services that are not covered by the terms of the plan or insurance contract.

Explanation of Benefits (EOB)—a document sent to an insured when a claim is handled by the plan or insurance company. The document explains how reimbursement was made, or why the claim was not paid, and if any additional information is needed. The appeals procedure should be outlined to advise the insured of his/her rights if there is dissatisfaction with the decision.

Extended Benefits—benefits which continue, or become payable, after the termination of coverage from a plan or insurance contract, for example, a hospitalization which continues after coverage would normally cease.

F

Face Amount—the death or maturity benefit payable on a Life Insurance policy.

Fringe Benefit Amount—the dollar amount per hour, or other period, which an Employer must contribute for each Employee under each applicable service contract.

H

Health Insurance Portability and Accountability Act of 1996 (HIPAA, also known as Kassenbaum-Kennedy Act)—a law that says that group health plans cannot deny an Employee's application for coverage based solely on health status. It also gives workers who change or lose jobs better access to health insurance.

I

ICD-9 Coding (International Classification of Diseases) - a system of codes that correspond to medical diagnoses.

Insurance Identification Cards (or ID Cards) —identification cards are used at the time plan members receive their medical care in order to facilitate proper claims handling. Among other things, ID cards indicate the plan member's Copayment and list the 1-800 numbers to call with questions. Replacement ID cards can be found in the section "Administration." ID cards should be received within approximately 2 weeks (10 business days) of the request.

L

Life Insurance Benefits—annual renewable term Life Insurance to protect families against hardship in the event of death of a covered Employee or dependent. No cash value will accumulate.

M

Mail Order Drug Benefit—this benefit allows covered persons to purchase maintenance prescription drugs through the mail in larger quantities than offered by local participating pharmacies.

Medicaid—a medical benefits plan available for low income persons paid by federal and state government, but administered by the state.

Medicare—a federal program of medical care benefits designed for those permanently disabled or over age 65.

Medically Necessary—many insurance policies will pay only for treatment that is deemed medically necessary to restore a person to health.

N

Network—Contracted providers of health care (physicians, hospitals, testing centers, rehabilitation centers, etc.) that have negotiated discount fees for their services in return for higher patient volume. This can apply to HMO, PPO, POS and EPO arrangements.

O

Open Enrollment Month—the allowed window of time that existing plan members have to make changes to their benefit elections.

Out-of-Pocket Maximum—the maximum amount that an insured is required to pay under a plan or insurance.

P

Participating Provider—a provider who has agreed to contract with a managed care program to provide eligible services to covered persons.

Pre-admission Certification—also called Pre-certification review, is the approval by a case manager or insurance company representative for a person to be admitted to a hospital or an inpatient facility in advance of admission into the hospital.

Preferred Provider Organization (PPO)—an organization of participating providers who have agreed to provide their services at negotiated discount fees in exchange for prompt payment and increased patient volume.

Prescription Drug Benefit—this benefit uses a network of participating pharmacies that have agreed to distribute prescription drugs at a discounted price.

Provider—A physician, hospital, skilled nursing facility, intensive care facility or health care professional or other entity which provides health care services.

Q

Qualifying Event—a qualifying event is an event that causes the covered Employee, or the spouse, or a dependent child of the covered Employee to lose coverage under the plan.

R

Reasonable and Customary—the maximum amount a plan or insurance contract will consider eligible for reimbursement, based upon prevailing fees in a geographic area.

Rider—an attachment to a certificate of insurance which provides additional benefits.

S

Schedule – list of benefits specific to your contract location and work schedule.

Service Area—a geographic area of operation for a managed care entity.

Subrogation—the right of recovery of one party against another party. This refers to the rights of the HMO or provider group to recover additional monies from a second insurance policy. In managed care, it refers mostly to an obligation of the provider group to use all legal remedies to repay the re-insurer for any claims paid, and whatever else they can collect.

T

Third Party Administrator (TPA)—an organization that provides specific administrative duties (including premium accounting, claims review and payment, arranges for utilization review and Stop Loss coverage) for a self-funded plan

W

Waiting Period—the time period between an eligible Employee's Date of Hire and their ability to receive benefits under a plan or insurance contract. An Employee who terminates employment or who leaves a covered contract before satisfying the Waiting Period is not entitled to benefits under the Plan or a refund of Employer paid Contributions.

Worker's Compensation Coverage -- programs mandated by the states which require Employers to provide coverage to compensate Employees for work-related injuries or disabilities

SCHEDULE OF SURGICAL BENEFITS

The following list of surgical procedures is a small sample of the many procedures that are too numerous to include here. To determine the CPT code for the procedure that your doctor has recommended, please check with the doctor's office. If the procedure is not listed in this Schedule of Surgical Benefits you may call the claims office with the CPT code to obtain the scheduled amount for the surgery.

CPT CODE	DESCRIPTION	ALLOWABLE AMOUNT
64866	Anastomosis, Facial-Spinal Accessory	$3,356.69
35092	Aneurysm Rupture, Aorta - Repair of	$5,965.83
35103	Aneurysm Rupture, Groin - Repair of	$5,099.99
33730	Anomalous Venous Return - Complete Repair	$5,964.31
22845	Anterior Instrumentation, Spine	$6,098.25
33845	Aorta Constriction - Removal of	$5,713.61
33411	Aortic Valve - Replacement/Aortic Annulus Enlargement	$7,239.05
33405	Aortic Valve- Replacement with Bypass	$7,065.18
35526	Aortosubclavian or Carotid Bypass Graft	$4,241.74
44950	Appendectomy	$1,314.17
22812	Arthrodesis, Anterior Spine	$7,521.10
69554	Aural Glomus Tumor - Excision	$4,939.28
61518	Brain Tumor, Infratentorial – Excision	$6,124.54
61521	Brain Tumor, Midline – Excision	$8,351.04
61576	Brainstem Surgery	$7,339.13
33315	Cardiotomy – Exploratory	$4,771.95
61705	Carotid-Cavernous Fistula	$7,026.26
43106	Cervical Esophagus Excision -Wookey Type	$4,917.52
56340	Cholecystectomy, Laparoscopic	$2,294.74
69930	Cochlear Device Implantation	$5,419.74
44153	Colectomy w/ Rectal Mucosectomy	$4,782.06
33575	Coronary Angioplasty	$8,269.16
33516	Coronary Artery Bypass	$9,789.56
63087	Corpectomy	$5,619.59
61501	Craniectomy for Osteomyelitis	$5,067.14
61526	Craniectomy Transtemporal	$6,874.12
61343	Craniotomy, Suboccipita	$6040.63
61545	Craniopharyngioma - Excision of	$8,811.00
62141	Cranioplasty	$4,488.90
51596	Cystectomy	$7,076.30
63180	Dentate Ligaments, Section of w/ Laminectomy	$4,799.25
24077	Elbow/Upper Arm - Radical Resection - Malignant Neoplasm	$2,056.17
43119	Esophagectomy w/Gastropharyngostomy	$4,799.75
37181	Esophagogastric Varices, Selective Decompression	$4,649.13
63290	Extradural-Intradural Lesion - Biopsy/Excision	$6,132.12
69725	Facial Nerve – Decompression	$4,680.97
20838	Foot, Replantation	$9,379.13
43620	Gastrectomy	$3,750.44
33335	Graft - Major Vessel	$6,454.60
35870	Grafts-Enteric Fistula, Repair of	$3,729.60

67108	Retinal Detachment	$4,786.61

CPT CODE	DESCRIPTION	ALLOWABLE AMOUNT
23472	Shoulder – Arthroplasty	$4,784.59
23077	Shoulder, Radical Resection - Malignant Neoplasm	$2,889.15
22140	Spine Reconstruction with Autograft, Allograft	$4,921.57
69970	Temporal Bone Tumor – Removal	$5,497.30
21243	Temporomndibular Joint – Arthroplasty	$4,959.98
63200	Tethered Spinal Cord w/Laminectomy	$4,703.72
33694	Tetralogy of Fallot – Complete Repair w/ Patch	$7,545.36
60254	Thyroidectomy	$5,500.81
31786	Tracheal Tumor or Carcinoma – Excision	$4,250.33
61541	Transection of Corpus Callosum	$5,155.59
33870	Transverse Arch Graft$	$9,770.35
33465	Tricuspid Valve – Replacement	$5,998.68
33786	Truncus Arteriosus - Total Repair	$8,665.94
69646	Tympanoplasty with Mastoidectomy	$4,338.78
50810	Ureterosigmoidostomy	$3,551.29
33545	Ventricular Septal Defect - Repair Postinfarction	$7,348.23
62201	Ventriculocisternostomy	$4,370.65
63304	Vertebral Corpectomy - Intradural, Cervical	$5,883.44
67036	Vitrectomy	$3,607.90
56640	Vulvectomy	$5,064.61

EXHIBIT 2I

Chimes/DC

Group Information Forms

Exhibits A-1 Through A-11

A-1	**$2.87**
A-2	**$2.59**
A-3	**$2.52/$2.87**
A-4	**$3.03**
A-5	**$2.78/$3.03**
A-6	**$3.30/$4.23**
A-7	**$3.25/$4.00**
A-8	**$2.24**
A-9	**$3.80/$2.85**
A-10	**$2.29**
A-11	**$472.51**

Exhibit A-1

Group Information Form

Eligibility and Funding Requirements

Company Information

Legal Name: The Chimes, DC, Inc.		
Address: 4815 Seton Drive		
City: Baltimore	State: MD	Zip Code: 21215
Phone: 410-358-6400	Fax: 410-358-0031	
Federal Tax ID#: 54-1691953	State of Incorporation: MD	
Contact #1: Al Bussone	Contact #2: Karen Holcomb	
Title: Vice President	Title: Benefits Coordinator	
E-Mail: abussone@chimes.org	E-Mail: kholcomb@chimes.org	

Contract Site

Site Name: Federal Bureau of Prisons	Code or Dept. #~: 230
Participation Date 10/1/05	Effective Date: 12/1/05

Contract Site

Site Name: Department of Commerce	Code or Dept. #~: 240
Participation Date 10/1/05	Effective Date: 12/1/05

Contract Site

Site Name: Dover AFB	Code or Dept. #~: 300
Participation Date 10/1/05	Effective Date: 12/1/05

Contract Site

Site Name: Southern Maryland District Courthouse	Code or Dept. #~560
Participation Date 10/1/05	Effective Date: 12/1/05

Contract Site

Site Name: Naval Support Activities	Code or Dept. #~: 100
Participation Date 10/1/05	Effective Date: 12/1/05

Contract Site

Site Name: Willow Grove	Code or Dept. #~: 110
Participation Date 10/1/05	Effective Date: 12/1/05

Contract Site

Site Name: Health & Human Services	Code or Dept. #~: 120
Participation Date 10/1/05	Effective Date: 12/1/05

Contract Site

Site Name: IRS Service Center	Code or Dept. #~: 130
Participation Date 10/1/05	Effective Date: 12/1/05

Contract Site

Site Name: IRS South:	Code or Dept. #~: 135
Participation Date 10/1/05	Effective Date: 12/1/05

Company Data

Plan Number: 501

Plan Type:	Limited Benefits & Major Medical	
Plan Design: (Ltd)	Family Plan	
Plan Design (MM)	Employee Only	
Employer Contributions $2.87		
Plan Fringe Amount: $2.87		
H & W Amount: $2.57		Other: $0.30 to DUB
Fringe Increase From: $2.59	Date: Various – See "Contract Site" Detail Above	
Funding:	**Fringe Rate Plan**	

New Benefit Waiting Period – Initially Eligible Group

Two Months After the Participation Date

Coverage Ends – Initially Eligible Group

One Month After Date of Termination

Waiting Period – Subsequently Eligible Employees

Two Months After the Participation Date

Coverage Ends – Subsequently Eligible Employees

One Month After Date of Termination

Exhibit A-2

Group Information Form

Eligibility and Funding Requirements

Company Information

Legal Name: The Chimes, DC, Inc.		
Address: 4815 Seton Drive		
City: Baltimore	State: MD	Zip Code: 21215
Phone: 410-358-6400	Fax: 410-358-0031	
Federal Tax ID#: 54-1691953	State of Incorporation: MD	
Contact #1: Al Bussone	Contact #2: Karen Holcomb	
Title: Vice President	Title: Benefits Coordinator	
E-Mail: abussone@chimes.org	E-Mail: kholcomb@chimes.org	

Contract Site

Site Name: Ariel Rios	Code or Dept. #~:200
Participation Date: 11/1/04	Effective Date: 1/1/05

Contract Site

Site Name: Social Security Administration	Code or Dept. #~: 500
Participation Date 12/1/04	Effective Date: 2/1/05

Contract Site

Site Name: Fort Bragg	Code or Dept. #~:
Participation Date: 05/6/05	Effective Date: 07/06/05

Contract Site

Site Name: Interstate Commerce Commission	Code or Dept. #~:
Participation Date 4/1/05	Effective Date: 6/1/05

Contract Site

Site Name: Service Disabled Veterans Administration	Code or Dept. #~:
Participation Date 4/1/05	Effective Date: 6/1/05

Contract Site

Site Name: USARC - Mobility	Code or Dept. #~:
Participation Date 03/14/05	Effective Date: 05/14/05

Company Data

Plan Number: 501		
Plan Type:	Limited Benefits & Major Medical	
Plan Design: (Ltd)	Family Plan	
Plan Design (MM)	Employee Only	
Employer Contributions $2.59		
Plan Fringe Amount: $2.59		
H & W Amount: $2.29		Other: $0.30 to DUB
Fringe Increase From: $2.36	Date: Various - See "Contract Site" Detail Above	
Funding:	**Fringe Rate Plan**	

New Benefit Waiting Period – Initially Eligible Group

Two Months After the Participation Date

Coverage Ends – Initially Eligible Group

One Month After Date of Termination

Waiting Period – Subsequently Eligible Employees

Two Months After the Participation Date

Coverage Ends – Subsequently Eligible Employees

One Month After Date of Termination

Exhibit A-3

Group Information Form

Eligibility and Funding Requirements

Company Information

Legal Name: The Chimes, DC, Inc.		
Address: 4815 Seton Drive		
City: Baltimore	State: MD	Zip Code: 21215
Phone: 410-358-6400	Fax: 410-358-0031	
Federal Tax ID#: 54-1691953	State of Incorporation: MD	
Contact #1: Al Bussone	Contact #2: Karen Holcomb	
Title: Vice President	Title: Benefits Coordinator	
E-Mail: abussone@chimes.org	E-Mail: kholcomb@chimes.org	

Contract Site

Site Name: Department of the Interior	Code or Dept. #~:270
Participation Date: 9/1/05	Effective Date: 11/1/05

Company Data

Plan Number: 501		
Plan Type:	Limited Benefits & Major Medical	
Plan Design: (Ltd)	Family Plan	
Plan Design (MM)	Employee Only	
Employer Contributions $2.52 Union / $2.87 Non-Union		
Plan Fringe Amount: $2.52 Union / $2.87 Non-Union		
H & W Amount: $2.52		Other: Union - $0.35 Pension / Non-Union - $0.35 to DUB
Fringe Increase From: $2.23 Union / $2.58 Non-Union	Date of Increase: 9/1/05	
Funding:	**Fringe Rate Plan**	

New Benefit Waiting Period – Initially Eligible Group

Two Months After the Participation Date

Coverage Ends – Initially Eligible Group

One Month After Date of Termination

Waiting Period – Subsequently Eligible Employees

Two Months After the Participation Date

Coverage Ends – Subsequently Eligible Employees

One Month After Date of Termination

Exhibit A-4

Group Information Form

Eligibility and Funding Requirements

Company Information

Legal Name: The Chimes, DC, Inc.		
Address: 4815 Seton Drive		
City: Baltimore	State: MD	Zip Code: 21215
Phone: 410-358-6400	Fax: 410-358-0031	
Federal Tax ID#: 54-1691953	State of Incorporation: MD	
Contact #1: Al Bussone	Contact #2: Karen Holcomb	
Title: Vice President	Title: Benefits Coordinator	
E-Mail: abussone@chimes.org	E-Mail: kholcomb@chimes.org	

Contract Site

Site Name: Pentagon	Code or Dept. #~:430
Participation Date: 10/1/05	Effective Date: 11/1/05

Company Data

Plan Number: 501		
Plan Type:	Limited Benefits & Major Medical	
Plan Design: (Ltd)	Family Plan	
Plan Design (MM)	Employee Only	
Employer Contributions $3.03		
Plan Fringe Amount: $3.03		
H & W Amount: $2.78		Other: $0.25 to DUB
Fringe Increase From: $2.78	Date of Increase: 10/1/05	
Funding:	**Fringe Rate Plan**	

New Benefit Waiting Period – Initially Eligible Group

Two Months After the Participation Date

Coverage Ends – Initially Eligible Group

One Month After Date of Termination

Waiting Period – Subsequently Eligible Employees

One Month After the Participation Date

Coverage Ends – Subsequently Eligible Employees

One Month After Date of Termination

Exhibit A-5

Group Information Form

Eligibility and Funding Requirements

Company Information

Legal Name: The Chimes, DC, Inc.		
Address: 4815 Seton Drive		
City: Baltimore	State: MD	Zip Code: 21215
Phone: 410-358-6400	Fax: 410-358-0031	
Federal Tax ID#: 54-1691953	State of Incorporation: MD	
Contact #1: Al Bussone	Contact #2: Karen Holcomb	
Title: Vice President	Title: Benefits Coordinator	
E-Mail: abussone@chimes.org	E-Mail: kholcomb@chimes.org	

Contract Site

Site Name: DeWitt Army Hospital	Code or Dept. #~:410
Participation Date: 10/1/05	Effective Date: 12/1/05

Company Data

Plan Number: 501		
Plan Type:	Limited Benefits & Major Medical	
Plan Design: (Ltd)	Family Plan	
Plan Design (MM)	Employee Only	
Employer Contributions $2.78 Union/$3.03 Non-Union		
Plan Fringe Amount: $2.78 Union/$3.03 Non-Union		
H & W Amount: $2.78		Other: Union $0.25 to Pension / Non-Union - $0.25 to DUB
Fringe Increase From: $2.62 Union / $2.82 Non-Union	Date of Increase: 10/1/05	
Funding:	**Fringe Rate Plan$**	

New Benefit Waiting Period – Initially Eligible Group

Two Months After the Participation Date

Coverage Ends – Initially Eligible Group

One Month After Date of Termination

Waiting Period – Subsequently Eligible Employees

Two Months After the Participation Date

Coverage Ends – Subsequently Eligible Employees

One Month After Date of Termination

Exhibit A-6

Group Information Form

Eligibility and Funding Requirements

(Company Information

Legal Name: The Chimes, DC, Inc.		
Address: 4815 Seton Drive		
City: Baltimore	State: MD	Zip Code: 21215
Phone: 410-358-6400	Fax: 410-358-0031	
Federal Tax ID#: 54-1691953	State of Incorporation: MD	
Contact #1: Al Bussone	Contact #2: Karen Holcomb	
Title: Vice President	Title: Benefits Coordinator	
E-Mail: abussone@chimes.org	E-Mail: kholcomb@chimes.org	

Contract Site

Site Name: Library of Congress	Code or Dept. #~:260
Participation Date: 10/1/05	Effective Date: 12/1/05

Company Data

Plan Number: 501		
Plan Type:	Limited Benefits & Major Medical	
Plan Design: (Ltd)	Family Plan	
Plan Design (MM)	Employee Only	
Employer Contributions: $3.30 Union/$4.23 Non- Union		
Plan Fringe Amount: $3.30 Union/$4.23 Non- Union		
H & W Amount: $3.30		Other: Union - $0.93 to Pension / Non-Union - $0.93 to DUB
Fringe Increase From: $2.95 (Union); $3.85 (Non-Union)	Date of Increase: 10/1/05	
Funding:	Fringe Rate Plan	

New Benefit Waiting Period – Initially Eligible Group

Two Months After the Participation Date

Coverage Ends – Initially Eligible Group

One Month After Date of Termination

Waiting Period – Subsequently Eligible Employees

Two Months After the Participation Date

Coverage Ends – Subsequently Eligible Employees

One Month After Date of Termination

Exhibit A-7

Group Information Form

Eligibility and Funding Requirements

Company Information

Legal Name: The Chimes, DC, Inc.		
Address: 4815 Seton Drive		
City: Baltimore	State: MD	Zip Code: 21215
Phone: 410-358-6400	Fax: 410-358-0031	
Federal Tax ID#: 54-1691953	State of Incorporation: MD	
Contact #1: Al Bussone	Contact #2: Karen Holcomb	
Title: Vice President	Title: Benefits Coordinator	
E-Mail: abussone@chimes.org	E-Mail: kholcomb@chimes.org	

Contract Site

Site Name: Andrews Air Force Base	Code or Dept. #~:570
Participation Date: 10/1/05	Effective Date: 12/1/05

Company Data

Plan Number: 501		
Plan Type:	Limited Benefits & Major Medical	
Plan Design: (Ltd)	Family Plan	
Plan Design (MM)	Employee Only	
Employer Contributions: Union - $3.25 Employee/$3.56 Family Non-Union - $4.00 Employee/$4.31 Family		
Plan Fringe Amount: Union - $3.25 Employee/$3.56 Family Non-Union - $4.00 Employee/$4.31 Family		
H & W Amount: Union $3.10 Employee/$3.16 Family Non-Union $3.13 Employee/$3.19 Family		Other: DUB Allocations: Union $0.15 Employee/$0.40 Family Non-Union $0.87 Employee/$1.12 Family
Fringe Increase From: Union - $2.98 Employee/$3.27 Family Non-Union - $3.70 Employee/$3.99 Family	Date of Increase: 10/1/05	
Funding:	**Fringe Rate Plan**	

New Benefit Waiting Period – Initially Eligible Group

Two Months After the Participation Date

Coverage Ends – Initially Eligible Group

One Month After Date of Termination

Waiting Period – Subsequently Eligible Employees

Two Months After the Participation Date

Coverage Ends – Subsequently Eligible Employees

One Month After Date of Termination

Exhibit A-8

Group Information Form

Eligibility and Funding Requirements

Company Information

Legal Name: The Chimes, DC		
Address: 4815 Seton Drive		
City: Baltimore	State: MD	Zip Code: 21215
Phone: 410-358-6400	Fax: 410-358-0031	
Federal Tax ID#: 54-1691953	State of Incorporation: MD	
Contact #1: Al Bussone	Contact #2: Karen Holcomb	
Title: Vice President	Title: Benefits Coordinator	
E-Mail: abussone@chimes.org	E-Mail: kholcomb@chimes.org	

Contract Site

Site Name: BWI/Milford Mills	
Participation Date: 8/1/05	Effective Date: 10/1/05

Company Data

Plan Number: 501		
Plan Type:	Limited Benefits	
Plan Design: (Ltd)	Family Plan	
Plan Design (MM)	Employee Only	
Employer Contributions $2.24		
Plan Fringe Amount: $2.24		
H & W Amount: $2.24		
Fringe Increase From: $2.04	Date of Increase: 8/1/05	
Funding:	**Fringe Rate Plan**	

New Benefit Waiting Period – Initially Eligible Group

Two Months After the Participation Date

Coverage Ends – Initially Eligible Group

One Month After Date of Termination

Waiting Period – Subsequently Eligible Employees

Two Months After the Participation Date

Coverage Ends – Subsequently Eligible Employees

One Month After Date of Termination

Exhibit A-9

Group Information Form

Eligibility and Funding Requirements

Company Information

Legal Name: Chimes, DC		
Address: 4815 Seton Drive		
City: Baltimore	State: MD	Zip Code: 21215
Phone: (410) 358-6400	Fax: (410) 358-0031	
Federal Tax ID#: 54-1691953	State of Incorporation: MD	
Contact #1: Al Bussone	Contact #2: Karen Holcomb	
Title: Vice President	Title: Benefits Coordinator	
E-Mail: abussone@chimes.org	E-Mail: kholcomb@chimes.org	

Contract Site

Site Name or Code: Fallon Federal Building		Dept. #:
Address: 31 Hopkins Plaza		
City: Baltimore	State: MD	Zip Code: 21201

Company Data

Participation Date: 03/01/05	Effective Date: 05/01/05	
Plan Number: 501		
Plan Type:	Major Medical	
Plan Design: (Ltd)	Family	
Plan Design (MM)	Employee Only	
Employer Contributions: $3.80 Non-Union / $2.85 Union		
Plan Fringe Amount: $3.80 Non-Union / $2.85 Union		
H & W Amount: $2.85		Other: $.95 DUB for Non-Union
Fringe Increase From: $3.75 Fringe	Date: 03/01/05	
Funding:	**Fringe Rate Plan**	

New Benefit Waiting Period – Initially Eligible Group

Two Months After the Participation Date

Coverage Ends – Initially Eligible Group

One Month After Date of Termination

Waiting Period – Subsequently Eligible Employees

Two Months After the Participation Date

Coverage Ends – Subsequently Eligible Employees

One Month After Date of Termination

Exhibit A-10

Group Information Form

Eligibility and Funding Requirements

Company Information

Legal Name: Chimes, DC		
Address: 4815 Seton Drive		
City: Baltimore	State: MD	Zip Code: 21215
Phone: 410-358-6400	Fax: 410-358-0031	
Federal Tax ID#: 54-1691953	State of Incorporation: MD	
Contact #1: Al Bussone	Contact #2: Karen Holcomb	
Title: Vice President	Title: Benefits Coordinator	
E-Mail: abussone@chimes.org	E-Mail:kholcomb@chimes.org	

Contract Site

Site Name: Ronald Reagan Building	Code or Dept. #-: 120
Participation Date 1/1/05	Effective Date: 1/1/05

Company Data

Plan Number: 501	
Plan Type:	Limited Benefits & Major Medical
Plan Design: (Ltd)	Family Plan
Plan Design (MM)	Employee Only
Employer Contributions $2.29	
Plan Fringe Amount: $2.29	
H & W Amount: $2.29	
Fringe Increase From: $1.63	Date: January 1, 2005
Funding :	**Fringe Rate Plan**

New Benefit Waiting Period – Initially Eligible Group

No Wait

Coverage Ends – Initially Eligible Group

One Month After Date of Termination

Waiting Period – Subsequently Eligible Employees

Two Months After the Participation Date

Coverage Ends – Subsequent Eligible Employees

One Month After Date of Termination

Notes

Pre-funding for the increased fringe amount was provided in a lump sum. This is why the Participation Date and Effective Dates are the same.

Exhibit A-11

Group Information Form

Eligibility and Funding Requirements

Company Information

Legal Name: The Chimes, DC, Inc.		
Address: 4815 Seton Drive		
City: Baltimore	State: MD	Zip Code: 21215
Phone: 410-358-6400	Fax: 410-358-0031	
Federal Tax ID#: 54-1691953	State of Incorporation: MD	
Contact #1: Al Bussone	Contact #2: Karen Holcomb	
Title: Vice President	Title: Benefits Coordinator	
E-Mail: abussone@chimes.org	E-Mail: kholcomb@chimes.org	

Contract Site

Site Name: Corporate Staff	
Participation Date: N/A – Not A Fringe Plan	Effective Date: 1/1/04

Company Data

Plan Number: 501		
Plan Type:	Major Medical	
Plan Design: (MM)	Family Plan	
Monthly Flat Rate: $472.51 – See Notes		
Increase From: $463.96		Date: 1/1/04
Funding:	Invoiced Plan	

New Benefit Waiting Period – Initially Eligible Group

No Lapse of Coverage

Coverage Ends – Initially Eligible Group

Midnight of the last day of the month of termination

Waiting Period – Subsequently Eligible Employees

First of the Month Following 60 Days of Continuous Employment

Coverage Ends – Subsequently Eligible Employees

Notes

Employer Cost: $472.51 Core; $472.51 Enhanced
Employee Cost: EE Only - N/A Core/$60.57 Enhanced
EE and Spouse - $432.26 Core/$556.06 Enhanced
EE and Child(ren) - $317.03 Core/$414.06 Enhanced
EE and Family - $759.44 Core/$934 Enhanced

Employer verifies that the information provided on these Group Information Forms:

Chimes/DC

By:_____

Title:_____

Date:_____

EXHIBIT 2J

FUNDING POLICY

FOR THE HEALTH & WELFARE PLAN OF

THE CHIMES, D.C., INC.

The Chimes, D.C., Inc., as a sponsoring employer ("Employer") hereby makes this Funding Policy, effective as of _____, 2004, under Section 2.3 of the Trust Agreement ("Trust") for the Health & Welfare Plan ("Plan") of Employer to implement the funding policy required under Section 2.3 of the Trust. The principal purpose of this Funding Policy is to insure that the Trust will have sufficient, readily available liquid assets in order to meet its obligations for payments required under the Plan and Trust.

The Plan will provide medical, dental, vision and related health and welfare benefits for certain eligible employees of Employer and their eligible dependents. Employer sponsor of the Plan will make periodic contributions to the Plan to fund those benefits generally as health and welfare expenses are incurred. Because the primary purpose of the Plan is to provide short-term health and welfare benefits, the primary investment strategy to be followed by the Trustee must stress the short-term liquidity needs and short-term stability of Trust assets.

Trustee will therefore invest the contributions of the Employer in such a manner so as to ensure security of Trust assets and provide sufficient liquidity necessary to meet the benefit payment requirements for administration of the Plan. Based on the above, the Funding Policy will be for Trustee to maintain the Trust's assets in short term, low-volatility investments including but not limited to money market accounts, interest bearing bank accounts, short term certificates of deposits.

This policy does not apply to the operational account. Employer reserves the right to change this Funding Policy on 30 days' prior written notice to Trustee.

EXHIBIT 2K

BUSINESS ASSOCIATE CONTRACT
Chimes District of Columbia
4815 Seton Drive
Baltimore, MD 21215
and
FCE Benefit Administrators Inc.
887 Mitten Road, Suite 200
Burlingame, CA 94010-1303

Definitions

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule of the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, *et seq*.

Examples of specific definitions:

a. Business Associate. "Business Associate" shall mean FCE Benefit Administrators, Inc..

b. Covered Entity. "Covered Entity" shall mean Chimes District of Columbia.

c. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

d. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

e. Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

f. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.

g. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

Whereas Covered Entity and Business Associate have entered into a prior agreement under which Business Associate may be provided Protected Health Information, the parties agree to be bound by the following:

Obligations and Activities of Business Associate

a. FCE Benefit Administrators, Inc. agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law.

b. FCE Benefit Administrators, Inc.agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. FCE Benefit Administrators, Inc. agrees to mitigate, to the extent practicable, any harmful effect that is known to FCE Benefit Administrators, Inc. of a use or disclosure of Protected Health Information by FCE Benefit Administrators, Inc. in violation of the requirements of this Agreement.

d. FCE Benefit Administrators, Inc. agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

e. FCE Benefit Administrators, Inc. agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by FCE Benefit Administrators, Inc. on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to FCE Benefit Administrators, Inc with respect to such information.

f. FCE Benefit Administrators, Inc agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by FCE Benefit Administrators, Inc on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, upon request in a reasonable time and manner or as designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

g. FCE Benefit Administrators, Inc agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

h. FCE Benefit Administrators, Inc agrees to provide to Covered Entity or an Individual, in a reasonable time and manner, information to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

Permitted Uses and Disclosures by FCE Benefit Administrators, Inc

General Use and Disclosure Provisions

a. Underlying services agreement:

Except at otherwise limited in this Agreement, FCE Benefit Administrators, Inc may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the underlying agreement between the parties, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

Obligations of Covered Entity

Provisions for Covered Entity to Inform FCE Benefit Administrators, Inc of Privacy Practices and Restrictions

a. Covered Entity shall notify FCE Benefit Administrators, Inc of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

b. Covered Entity shall notify FCE Benefit Administrators, Inc of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect FCE Benefit Administrators', Inc. use or disclosure of Protected Health Information.

c. Covered Entity shall notify FCE Benefit Administrators, Inc of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect FCE Benefit Administrators', Inc use or disclosure of Protected Health Information.

Permissible Requests by Covered Entity

Covered Entity shall not request FCE Benefit Administrators, Inc to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

Term and Termination

a. Term. The Term of this Agreement shall be effective as of May 16, 2003, and shall terminate when all of the Protected Health Information provided by Covered Entity to FCE Benefit Administrators, Inc, or created or received by FCE Benefit Administrators, Inc on behalf of Covered Entity, is destroyed or returned to Covered

Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by FCE Benefit Administrators, Inc, Covered Entity shall either:

1. Provide an opportunity for FCE Benefit Administrators, Inc to cure the breach or end the violation and terminate this Agreement (and the prior Agreement) if FCE Benefit Administrators, Inc does not cure the breach or end the violation within the time specified by Covered Entity;

2. Immediately terminate this Agreement (and the prior Agreement) if FCE Benefit Administrators, Inc has breached a material term of this Agreement and cure is not possible; or

3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

c. Effect of Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, FCE Benefit Administrators, Inc shall return or destroy all Protected Health Information received from Covered Entity, or created or received by FCE Benefit Administrators, Inc on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of FCE Benefit Administrators, Inc shall retain no copies of the Protected Health Information.

2. In the event that FCE Benefit Administrators, Inc determines that returning or destroying the Protected Health Information is not feasible, FCE Benefit Administrators, Inc shall provide to the Covered Entity notification of the conditions that make return or destruction infeasible. Upon notification that return or destruction of Protected Health Information is infeasible, FCE Benefit Administrators, Inc shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as FCE Benefit Administrators, Inc maintains such Protected Health Information.

Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

c. Survival. The respective rights and obligations of Business Associate under Section covering "Effect of Termination" of this Agreement shall survive the termination of this Agreement.

d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

In witness whereof, each of the undersigned has caused this Agreement to be duly executed in its name and in its behalf effective as of July 22, 2003.

Covered Entity

By: Lee A. Bussone

Print Name: Lee A. Bussone

Title: Director, HR

Date: 7/22/03

FCE Benefit Administrators, Inc

By:

Print Name: Steve Porter

Date: 7-22-03

Date: 7-22-03